HEALTH CARE CRISIS; PROBLEMS OF COST AND ACCESS

HEARING

BEFORE THE

TASK FORCE ON HUMAN RESOURCES

OF THE

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HOUSE OF REPRESENTATIVES

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CONTENTS

	Page
Statement of:	
Arce, Gabriel, Chief Executive Officer, San Ysidro Health Center	12
Bates, Hon. Jim, a Representative in Congress from the State of California	2
Beck, Judy, R.N., Nursing Supervisor, San Diego City Schools	35
Blomberg, Patty, Deputy Director, Sacramento AIDS Foundation	83
Bowen, Dr. Nancy L., Chief, Maternal and Child Health, San Diego County	38
Burnett, Cynthia, Health Programs Administrator, the Women's Civic Improvement Club of Sacramento, CA	80
Casaday, Carol, Executive Director, Chemical Dependency Center for Women	72
Davis, Ms., A Woman With AIDS	78
Fazio, Hon., Vic, a Representative in Congress from the State of California	55
Filner, Hon. Bob, Councilman, City of San Diego	6
Firth, Lisa, Regional Coordinator, San Diego and Imperial Counties Regional Perinatal System	32
Flynn, Dr. Neil, Director, AIDS and Related Disorders Clinic, University of California, Davis	76
Harry, Randi L., Associate Director, Hospital and Clinics; Director, Financial Services, University of California, Davis, Medical Center	63
Hinton, Dr. Bette, Sacramento County Health Officer	93
Hoekenga, Susan, Executive Director, ElderHelp of San Diego	48
Irwin, Mary, Planning and Research Director, Community Services Council, Inc.	95
Johnson, Hon. Grantland, Chairman, Sacramento County Board of Supervisors	55
Killea, Hon. Lucy, California State Senator	3
McCandliss, Len, President, the Sierra Foundation	67
Rudin, Hon. Anne, Mayor, City of Sacramento	53
Sadler, Blair L., President and CEO, Children's Hospital and Health Center	26
Simms, Paul B., Deputy Health Director for Physical Services, San Diego County	8
Simon, Dr. Gil, Sacramento Children's Medical Center	88
Stennes, Dr. Richard, Physician, San Diego County	13
Stern, Joe, Senior Advocate, San Diego County	43
Usher, Ronald K., Ph.D., Director, Sacramento County Health Department	60
Williams, Hon. Leon, Chairman, San Diego County Board of Supervisors	4
Willis, Winnie, Ph.D., Associate Professor, San Diego State University	41
Prepared statements submitted by:	
Arce, Gabriel	102
Beck, Judy	120
Bowen, Dr. Nancy L.	121
Burnett, Cynthia	149
Casaday, Carol	152
Davis, Ms.	159
Fazio, Hon. Vic	134
Findeisen, Nancy	167
Flynn, Dr. Neil	157
Firth, Lisa	115
Harry, Randi L	162

Prepared statements submitted by—Continued Page
Hinton, Dr. Bette 143
Hoekenga, Susan 131
McCandliss, Len 161
Sacramento AIDS Foundation, from the publication HIV 2000, presented by Patty Blomberg 140
Sadler, Blair 127
Simon, Dr. Gil, with attachments 135
Stennes, Dr. Richard, with attachments 103
Usher, Ronald L 165
Willis, Winnie 125

HEALTH CARE CRISIS: PROBLEMS OF COST AND ACCESS

WEDNESDAY, OCTOBER 31, 1990

HOUSE OF REPRESENTATIVES,
TASK FORCE ON HUMAN RESOURCES,
COMMITTEE ON THE BUDGET,
San Diego, CA

The Task Force met, pursuant to notice, at 9:10 a.m., in room 310, San Diego County Building, Board of Supervisors Chambers, 1600 Pacific Highway, San Diego, CA, Hon. Barbara Boxer, Chair, presiding.

Mrs. BOXER. Good morning. I am Congresswoman Barbara Boxer, and I am very pleased to be here in San Diego for one of several meetings the Task Force on Human Resources has been holding throughout California and in Washington, DC.

To really assess the state of health care in this country, I am going to ask Councilman Filner to take his seat next to Senator Killea and Supervisor Williams, and we will open up the panel in a moment. But, we will have a couple of opening statements. I am really very pleased to be here, and I welcome everyone to this field hearing.

The Task Force is charged with the responsibility of recommending funding levels for education and health programs to the full Budget Committee. During the 2 years of my chairmanship, the Task Force has highlighted some of our most critical health care needs. Over the last year, the Human Resources Task Force has held hearings on AIDS, Medicare, biomedical research, veterans' health care, and the WIC program—women, infants, and children's program.

The people best able to advise us on health care issues are the people fighting the battles on the front lines. That is why we are out here today—to find out how people in our California communities are coping, to identify key problems—and perhaps some innovative responses to take back to Washington.

We are aware of some shocking statistics. As many as 37 million Americans have no health insurance coverage at all. Medicaid serves only about half of our poor children—while 20 percent of our children are below the poverty line. The United States ranks behind 19 other industrialized nations in our infant mortality rate—we have 40,000 infant deaths per year. Over 70,000 babies are born every year to women who have had no prenatal care.

These figures are all the more disturbing in light of the tremendous resources we devote to health care. I have long advocated an

approach to health programs based on the cost-effectiveness of early intervention. We have to reach out to people before they are ill, or pregnant, or hooked on drugs.

We are bringing together today local elected officials, health care providers, and community advocates, to dramatize health care issues. Many of the issues that were debated so visibly in recent weeks will be fought again next year. And, you have an early opportunity, through this hearing, to send a message that will be carried back to Washington.

I am very pleased that Congressman Jim Bates has joined us here this morning. He has an hour to spend with us.

I want to make it clear that although Congress did not look so beautiful or so pretty the last few weeks, there was a reason why we had to fight. Why we did not just roll over. The reason, really, could be best characterized as M and M—Medicare and millionaires. We stood our ground. Jim Bates was right there with me, doing that. We said, the millionaires had to pay their fair share, pay their way, help us in this budget crisis. And, we said that we would not balance the budget on the backs of the elderly, and their health care system that they need so much.

So, it is my privilege and pleasure at this time to turn to my good colleague, Jim Bates.

STATEMENT OF HON. JIM BATES, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. BATES. Thank you. Congresswoman Boxer, it is a pleasure to be here this morning, and to see people here in this room and on the panel, who have been doing the things that need to be done to focus on health issues. I would just like to say that Congresswoman Boxer has taken over the Human Resources Task Force on the Budget Committee, and has really made that an active forum for pursuing, in depth, the review and look at programs that need to be addressed by the Congress. I think she should be commended, and I would like to do so here, while she is here visiting us in San Diego.

Mrs. BOXER. Thank you, Jim.

Mr. BATES. San Diego, as you know, has traditionally been underfunded with respect to health care, primarily because the State formula has tended to skew toward Los Angeles and the Bay Area on a historical pattern. And, I understand the board of supervisors has a lawsuit or something going on there. But, I hope you prevail.

But, I do think this gives us an opportunity to talk about the issues, and I look forward to hearing from you. I think, not only in the budget do we have to deal with the millionaires who have not paid their share, and Medicare, which needs to be protected, but I think there were a lot of areas where we could have cut far more. Particularly, in defense and farm programs, and hopefully, we will begin to look at that.

I see with the interest on the debt alone, the debt rising so fast, and the interest on the debt, I think it is time to look at moving away from the Federal Reserve System, where we borrow private money and pay interest, to printing our own money where we owe ourselves, and would not have those exorbitant interest amounts.

And, I think, probably, as that debt takes 30 and 40 percent of our total budget, that idea, I think, will have a lot more support.

Anyway, I look forward to hearing from our panel. Thank you for inviting me.

Mrs. BOXER. Thank you, Congressman. At this time, it is a pleasure for me to introduce our first panel, Hon. Lucy Killea, one of my heroines; Hon. Leon Williams, chairman of the San Diego County Board of Supervisors; and Hon. Bob Filner, councilman of the city of San Diego.

I think that these three examples of good elected officials is just the perfect tone to open our hearing. It is a pleasure to introduce Senator Killea.

STATEMENT OF HON. LUCY KILLEA, CALIFORNIA STATE SENATOR

Ms. KILLEA. Thank you very much. Is that coming through?

Mrs. BOXER. Yes.

Ms. KILLEA. I really appreciate your coming, and welcome you here. And I think you have gathered today a very helpful and knowledgeable group of professionals in the health field. And I think you can get a lot of information from this, so I am hopeful this is going to be a very fruitful hearing.

I personally know many of the individuals you have on these panels, and all of them are well qualified to discuss aspects of health care, here on the local level, as well as throughout the State. You know, there are so many problems today, but I think, often, when we talk about the larger picture, we lose sight of the components in it that are so important.

For instance, the one that is, I think now, grabbing our attention because it is such a poignant problem, is the drug-addicted babies being born to addicted mothers. I was at the Las Colinas jail last night, attending a class under a program called PIP. It stands for Pregnant Inmate Program. And the women come in voluntarily. It has a small part of Federal funding and has other sources of funding with it. But it is a pilot project, and they give the women basic lessons in three aspects.

One, their drug addiction, what it does to their body, and what it does to the baby, the fetus, and so on.

Then, they do another one, on another night of the week, is on—this is where I attended—simple lessons in anatomy, which many of them do not have. And how they get pregnant, and how they keep from getting pregnant. They were learning things that seem very basic, but many of them never had an opportunity to learn it before.

The third part of it is devoted to recovery. What, as they leave jail, they can do. The resources that are out there. And there is a helping hand for them to recover. This is empowering the women, themselves, to take control of their lives.

And I think this is the way we have to go. We simply cannot be taking care of every single problem of every person. We have to empower them to take care of themselves. This is only one small program. There are many wonderful ones. This is an area that we must give more emphasis to, and I really appreciate your being

here, because I think it highlights for us, as you note from our press of the last few days, if you have been seeing some of it, we do have some problems in meeting the needs of pregnant women in this county. Thank you.

Mrs. BOXER. Thank you very much, Senator. Supervisor Williams?

STATEMENT OF HON. LEON WILLIAMS, CHAIRMAN, SAN DIEGO COUNTY BOARD OF SUPERVISORS

Mr. WILLIAMS. Thank you very much, Congresswoman Boxer. And I want to welcome you, particularly, to this beautiful county. I know that you have been a member of a board of supervisors, and you know what the problems are.

And Congressman Bates, of course, has been sitting right in this very chair that he is sitting in right now in years past, so I really want to welcome you here.

But I also want to say a couple of things about what you said, about the Congress looking bad. I personally do not share that view. People are saying that all over the nation. But I think people who say that do not realize what a great nation this is. This is a big nation, multiethnic, multiregional, with many different and multiple interests.

And if you look at some of the smaller nations in the world, they have a lot more turmoil in their governments than we do, with this massive nation. So I do not think you people should let people put you down. I think you ought to say that you have a right, and a duty, and an obligation, to represent your districts. And to do the best you can, as you see what it is that ought to be done.

There are some things that might be done to smooth out the operations of the Congress, but I do not think that we should apologize for the things that need to be done, and put ourselves in a negative position. So I just wanted you to know that is at least one person who thinks that you guys are doing okay.

Mrs. BOXER. Much appreciated.

Mr. WILLIAMS. Now, on behalf of the Board of Supervisors of the County of San Diego, and the, I believe, nearly 2½ million residents, I want to extend greetings to you, and sincere appreciation to you and Congressman Bates for coming to San Diego to better understand the access to care issues. Particularly, San Diego County is the second largest county in the State of California, and we have, probably, one of the most significant influx board of problems, and problems that generated around the health care system, because of that border situation.

And I am not saying that there is anything wrong with people seeking to get medical care. Because if I were personally in a situation like that, I would try to get medical care by whatever means. So I think the situation is here that we need to deal with, without casting blame on anybody.

San Diego has a number of challenges. It is trying to orchestrate care for indigent people. Being the second largest county in California, we do not have a hospital. And some people have problems with that. But we see that not having a hospital may be an advantage. Because of a 4,200 square mile county, if we had one single

hospital, we would have people trying to access that facility for many miles away. So by being able to contract with care providers throughout the region, we believe that we are able to provide better care than we would, if we tried to limit it to one location.

Today, there are going to be some panelists that Ms. Killea already referred to. And I know all of them, too. They are very able and capable people. And they are going to have a lot of details about the problems of underfunding in San Diego. And lastly, I believe it is important to note that this hearing will simulate the dialog leading up to what we believe will be a major board of supervisors conference on indigent care access, which has already been scheduled for December 18.

The problems are beyond any single county. The financing to solve access problems of the 37 million uninsured Americans will have to emerge at the Federal level. And I know you know that, or else you would not be here. States, first, must ultimately redesign their Medicaid systems, to facilitate physician, hospital and patient access. At the local level, you must continue to breathe life into public/private partnerships. Whenever the County of San Diego has succeeded in providing care to indigent and poor communities, it has been as a result of effective planning, with all provider and consumer groups.

We are committed to continuing dialogue, exploring new mechanisms to finance, to enhance access among those clinics and hospitals, and physician groups, which have been faithful to working poor and indigent patients. Let us continue with the persistence and caring of a Nelson Mandela, whose struggle has inspired us all.

I want to say just a couple of words about what Mrs. Killea mentioned, the perinatal care. Here in this county, we know that we could provide, if we had the machinery together, we could provide the care for many women, for as little as $500 or $600. Failing to provide that care, many of those low birth weights and other complicated births result in an average of $31,000 per birth, for the first 2 or 3 weeks of life, and many of those die after that period of time. And the cost can range as high as $60,000 or more, per such birth.

So if we could provide perinatal care for those women, and many of them are very young women without appropriate guidance, we could solve many of the problems of that high cost medical care. We could solve subsequent problems, in terms of higher medical costs as the person survives, and then, further costs, as they very often are, have some problems with learning in schools, we could solve some of those problems. Then, we have other problems that go into the justice system. A high number of those people, with those kind of birth complications, drug related as we know, enter the justice system.

So I think your thrust of prevention is a very, very important one, and of course, that is the thrust we are taking here in this county. And I have made it, during my year as Chairman, our principal thrust to move toward prevention. And I think that we are, as the British used to say, penny wise and pound foolish, to fail to provide services at the levels where we could solve problems, and not let them continue to be generated in our society.

Mrs. BOXER. Thank you very much, Supervisor. Councilman Filner, welcome.

STATEMENT OF HON. BOB FILNER, COUNCILMAN, CITY OF SAN DIEGO

Mr. FILNER. Thank you, Chairperson Boxer, Congressman Bates. It is a pleasure to welcome you to the city of San Diego. I am glad that you have selected our county as one of those to hold hearings. We are not atypical, like many other communities in the state. The access to the health care is limited by a number of factors, including, of course, those that you talk about in the title—cost and accessibility.

And it is our hope that the testimony you will hear today will provide you with a look at the health crisis right here in San Diego County. Now, I represent San Diego city government, a level of government that does not have the kind of statutory authority in the health crisis. But I represent the eighth district of the city of San Diego, a seat that has a tradition of concern, sensitivity, and activism on this issue.

Congressman Bates was the first occupant of the district eight seat, almost 20 years ago. Senator Killea held the same seat with great distinction. And so I have some important and big shoes to follow in. And we all know, when they served at city level, that political leadership at all levels is necessary to come together to deal with a comprehensive issue that affects all our constituents, like health care.

Certainly, what we see in San Diego is not atypical. The current downturn of our economy, coupled with the high cost of housing, is placing an unbearable strain on both middle and low income residents in our community. And health care is rapidly becoming unaffordable, even to those of us that could afford to purchase it in the past. An ever increasing number of families are unable to purchase the preventive health care services that are necessary, and are reduced, of course, to receiving that care only in the most life threatening circumstances.

The parents who fall in this group, cannot find, as we have heard, the prenatal care. We have increased infant mortality and low birth weight babies. And the youngsters that have the ear infections, the asthma, the bronchitis, and other nonthreatening but very painful conditions, are going without that necessary care. And all the preventive care, routine examinations, whether for hearing or vision, dental, are just too expensive. And we know that that will limit participation in their futures, in educational and development activities.

And if those basic health needs, mental health care is even more severely lacking. The alienation, the depression, that many young people encounter as they face the challenges of the modern world, requires treatment by health professionals. And we just cannot simply count on the police and the justice system to solve those problems that our young people are facing.

Many of our mentally ill, as you well recognize, are homeless. The eighth district includes downtown San Diego, where the vast majority of the homeless are found. And life on the streets is ex-

ceedingly rough on families and children. Yet a mentally ill mother will raise her children on the streets, if she remains undiagnosed and untreated. And no child should be penalized because he or she was born into a home where there is mental illness, or illiteracy, poverty, drug abuse, or unemployment.

We lose adults to the heart disease, diabetes, alcoholism, and cancer, that if diagnosed, treated in a timely fashion, can be cured, and would not result in the high cost to the community that we see.

Our elderly continue to be terrorized by the mounting cost of basic necessities, and the menace of budget cuts, as you referred to. And we appreciate your fight on behalf of all of us in Washington. Their only hope is that we learn to appreciate the wisdom of their years, and the contributions which they make to our lives. And we must recognize the value of humanity, whether or not they have a certain level of income.

We need your help. San Diego needs the cooperation of the Federal and State governments to develop a comprehensive health care system that is affordable and accessible to all. We at local government want to work with you to develop that comprehensive program. We need to place it, as both the senator and the Chair of the county board have stated, at the very top of our political agenda.

I do not need to tell you all, or the people in this room, that health care is critical to the dignity in life. And it should be a right of all, not just a privilege of a few. Thank you for allowing us to—to bring us together again, and to reinforce our commitment to this county and to our citizens.

Mrs. BOXER. Thank you very much, Councilman. And before you leave, we just want to thank you appropriately. So Congressman Bates, do you have any parting comments for our colleagues, here?

Mr. BATES. No. I was taken by the comments of Senator Killea on the infants and that program. I think in all of those cases, it is obvious that we need better funding, and we need to be addressing those problems, and we are not. And certainly, the idea of preventative health care is one that is so obvious and so cost effective, and yet, we are not moving in that direction. And that disturbs me, and I really am grappling here with the answer. And hopefully, as we get to other testimony today, some ways to move us in that direction will be forthcoming.

But I want to thank you for being here, and for your comments.

Mrs. BOXER. Thank you, Congressman. I would just say, before you all leave us, that this community is very fortunate that the elected officials who spoke to us today have a sensitivity and a real caring about what is happening out there in this community. And an understanding of what has to be done.

I think the notion that the senator put forward, of lifting people up to give them the strength to prevent problems from happening, is very crucial here. And Chairman Williams' point about, certainly, prevention. And the special problems of the border that you face. And Congressman Bates has long been telling us about this, since he came to Congress. And I think, sometimes, we are all so involved in our own districts, we do not realize this is a special added problem, and it is important that it be recognized and brought out.

And to Councilman Filner, who presents to us the reality of some of the harsher sides of San Diego. It is amazing, because people look out, and it is such a magnificent place, that you simply do not see the problems. It is like some places up north, that I know very well. But they are out there, and they have to be recognized. And you are out there.

And all that I can say is the tradition of that eighth district seat is quite incredible. And great things ahead for anyone who runs for that seat, I think. So I want to thank all of you for being here. And you know that I will work with you. We will send this testimony to my colleagues on this Task Force. I will talk about this hearing with Congressman Leon Panetta, who heads up the Budget Committee. And you can be certain that your ideas will be heard in Washington.

Thank you, the three of you, very, very much. Thank you all. Nice to see you all.

And I would call, for our next panel, Paul Simms, deputy health director for physical services, San Diego County; Gabriel Arce, executive director of the San Ysidro Health Center; and Dr. Richard Stennes, physician. We welcome all of you. We welcome this panel, and I would ask you, if you can, summarize your testimony in 5 to 7 minutes. We will put the entire testimony into the record. If you feel you need a couple of extra minutes, that is fine as well. But we want to save some time for questions.

So we are going to ask Mr. Simms to begin, and we welcome you to this hearing.

STATEMENT OF PAUL B. SIMMS, DEPUTY HEALTH DIRECTOR FOR PHYSICAL SERVICES, SAN DIEGO COUNTY

Mr. Simms. Thank you, Chairperson Boxer and Congressman Bates. Good morning. Thank you. On behalf of Dr. Cox, greetings, and I think it indeed important that you come to San Diego to explore some of those issues unique to health care access.

We need to take this opportunity to thank Congressman Bates for his leadership in the trauma bill. It will indeed make a difference. The preventable deaths here in San Diego have been reduced by 90 percent as a result of the trauma system in San Diego, and your bill will facilitate the implementation of other systems in the nation.

From an access to care perspective, I think it important to recognize that one of the real serious issues around access has to do with the barriers that have been created between physicians and patients, and between physicians and the system. By this I am saying, if you look at some of the administrative practices of Medicaid reimbursement, here in California, for example, California boasts nearly the lowest—47 out of 50 States, in terms of physician participation in the Medi-Cal program.

That is a reflection of payments that are too low, payments that are too late, payments as a result of a system that sequentially scans a bill, and when it finds a problem, it sends the bill back. And when that problem is fixed, the bill is resent, and it scans along and finds another problem. I have seen physician checks for $12, after seven attempts to get paid from the Medi-Cal system in

California. And that will cause physicians to reject participation, and that will deny access to poor people in this Nation.

This is not a problem unique to California. I was in New York State last week at the Institute for Man and Science, and there were states trying to grapple with the problem of access, but had not looked deep enough into their own bureaucracies.

So it occurs to me that if you look at obstetricians in San Diego County, three out of four obstetricians here currently refuse to accept a new, poor, pregnant woman. And when you ask them why, the first two reasons that constitute over 60 percent of their rationale, is the reimbursement rate and the bureaucracy itself. So something must be done. And the problem is, we have to put how the system approaches the providers themselves.

I think hospitals survived the sixties and the seventies by being able to cost shift. If they did not get enough reimbursement from one payor, they simply inflated the rates for the other players. Well, competition has made America great, but competition has also taken all the fat out of the health care reimbursement system.

So much so, that institutions like San Diego Physician's and Surgeon's Hospital, which is now called San Diego General Hospital, is bordering on the brink of closure. It is the institution in the middle of a predominantly minority community in San Diego. You have the highest concentrations of underpaid and unpaid emergency patients. You cannot move a hospital. So the hospital must either function with some kind of recognized increased support—a kind of accelerated disproportionate payment for its position, greater than 5 percent. Or, it will have to close.

And we see infant mortality continuing to kill black infants at twice the rate of white infants. I serve as the chairman of the Medi-Cal Access Commission for the California Black Infant Health Leadership Committee. When we began to examine infant mortality, we found that there were problems of both understanding how to be a good parent, understanding how to be a good mother. The need to develop programs and parenting skills, so that as you say, persons can be empowered to get better control of their health care.

At the same time, hospitals have got to know that this is our patient population, and these physicians will be accepting those patients. That kind of organized system, one that we have struggled trying to design here, does not now exist in this country. And I suggest that, perhaps, there need be Federal intervention in this regard.

Finally, when we start looking at health care cost increases, we find a number of phenomena over which, in all candor, we will have no control. We will not have any control over the medical education in this country, which is driven by technological imperatives. Medical students are educated at high tech institutions, with CAT scans and NMRs, and the kind of rural, the kind of underserved area problem is going to run head along into a technologically trained physician. And that will continue.

High malpractice awards will force physicians to practice defensive medicine. Between 3 and 10 percent, I have been told, of all health care costs, are due to physicians trying to protect themselves from litigious patients.

The industry continues to be fragmented. Out patient records rarely find their way into the inpatient system. We have specialized and subspecialized to a point that there is no overall care manager, when someone gets into one of these high tech systems. And that lack of coordination is costly. It seems to me that we are paying, as patients, for the technological advances which we enjoy. Persons who would have died 20 years ago are now living. And they are living as a result of technology. And we cannot turn the clock back. It is like trying to unscramble an egg.

Those technological advances will cost this Nation a certain amount of money. Unfortunately, we have had a governmental performance which has attempted to defy the economic realities of this country. We have Medicaid systems, statewide, which are attempting to broker provider payments, while failing to recognize that increases in inflation, and increases in population of persons have got to translate into increases in budget. If they do not do that, the only option is for patients to be jettisoned from eligibility.

Unfortunately, the medically indigent adult program in San Diego suffers under a State budget approach with a flat line. A flat line in the health care industry means it is dead. We had to drop 8 percent of the population in 1988, in order to keep the provider system intact. So I know from whence I come here locally. The approach of building in incremental increases to cover some part of the inflationary cost and some part of the increase and demand, must be a Federal tenant that is sacrosanct. Otherwise, government attempts to go out into the economic arena and engage in business with practices which are counterintuitive.

There is no reason why a physician would continue to play in a Medi-Cal reimbursement or Medicaid reimbursement game, and be treated as if he or she was an adversary.

In conclusion, it seems there are five possible options. The first is that we must provide adequate incentives to bring patients back together with practicing physicians. And it is not only money, it is approach. Pay—there should be a performance standard that says, in my opinion, physicians get paid in 30 days from the receipt of a bill. And be paid at least to cover the cost. If you will not cover usual and customary charges, at least let physicians not lose money in treating poor patients. Hospitals should not lose money in treating poor patients. Currently that is the case in this country, as a result of the Medicaid budget caps, and it is counterintuitive. No. 1.

No. 2—Congress should develop, in my opinion, a strategy which recognizes these concentrations of underserved patients, and there should be some specific payments, some front line payments, some accelerated payments, to both the hospital such as San Diego General Hospital, and the physicians that serve the Logan Heights and the southeast San Diegos of this Nation.

Third, have either of you seen a Medi-Cal application? I have two in my car. I will bring them to you. In this county, it is a 16-page tribute to a barrier to access. Now, when—and again, in this National Center for Health Services Research meeting, this agency meeting last week, we were looking at systems that stimulate access. There are some states that have taken this 16 and 20 page document for poor, pregnant women, and they have reduced that

document to two pages. I have a copy. This should, in my opinion, be a national standard. If you are poor, and you are pregnant, you should not have a 20-page document to go through. It should be a two page document.

Senator Watson—Dianne Watson in this State—adopted and designed a bill 2705, which would say that once a woman is pregnant and on Medi-Cal and poor, that she be eligible through her pregnancy, 60 days postpartum. She is not going to get unpregnant. Why should she get dropped from Medi-Cal, after Medi-Cal decides that she is pregnant. This also should be a national policy, that once a woman is declared Medicaid eligible, that she be eligible through 60 days postpartum. And in that way, she will not get out 6 months, fail to complete some form, get lost in the mail, get dropped from Medi-Cal, wind up in the hospital delivery, the hospital not get paid, the doctor not get paid.

That drives physicians and providers away from the system. And we do not really want that. And we are smart enough, it seems to me, to design systems that can close these gaps.

Two other points and I will conclude. You are absolutely right that prevention needs to be higher on our policy plate than it has ever been. Smoking is suicide, and people need to be confronted with that, in no uncertain terms. It is a culturally sensitive mode. We need strong young men and women, who can look drugs in the face, as prevalent as they are in minority communities, and say no, even if there are no good alternatives.

Part of—25 percent of all Californian children are currently born out of wedlock. For black children, it is 62 percent. We must get back to building strong families. And I think the Federal Government, if you talk about cost of payments, has got to have that on its organizational plate.

Lastly, it seems to me that insurance works well as part of this current economy. But if you are outside of the economy—if you are the 37 million who are uninsured—a significant number of whom are unemployed—an insurance product design does not work. But we have got to figure out some mechanism to take the middle person out, to make the payment go directly to the provider to cover costs. And it seems that a national task force, while there has been tremendous focus on national health insurance and universal health insurance, that comes out of our egos. It comes out of our national priorities for economic well being, and economic worth.

There is a strong work ethic in this country, and insurance has been a function of work. But if you are marginally employed, or unemployed, you do not get the access, because you do not have the insurance. Well, we cannot force our egos onto a community or persons who are marginally employed. A different solution seems to be asked for.

In conclusion, we are committed at this level, as Supervisor Williams outlined. It is kind of a three-tiered approach. There have to be adequate resources provided at the federal level. The State has got to reorganize its Medicaid program, in order to facilitate access for the categoricals. And at the local level, we must continue effective public/private bargaining. Thank you.

Mrs. BOXER. Thank you. I hope you will stay, because I want to make some comments about your testimony. Mr. Arce.

STATEMENT OF GABRIEL ARCE, CHIEF EXECUTIVE OFFICER, SAN YSIDRO HEALTH CENTER

Mr. ARCE. Congresswoman Boxer, Congressman Bates, good morning. I am Gabriel Arce, chief executive officer of San Ysidro Health Center. I represent one of the largest community health centers in the Nation funded by the Public Health Service under the Department of Health and Human Services. Today, I want to talk about access to care in our part of the world, or the lack of it. Over the years, the Federal Government has developed a network of community health centers throughout the Nation to assure access to care for the low income, the minorities, the poor, the homeless, pregnant women, newborn children, and so forth.

But the need for such a delivery system has far exceeded the Federal Government's ability to expand the network of community health centers. In some cases, the states have stepped in and funded similar delivery systems. In our case, the county has picked up the funding slack, and the community clinics have provided the care. But as the provider of last resort in this State, the counties can no longer cope with the demands for health care, any more than they can cope with the demands for other services—and this leaves too many people without access to care.

Moreover, private providers have been pushed to the limit in terms of offering free or subsidized care, and it is no longer reasonable to expect them to continue meeting the responsibilities on behalf of the cities, counties, states and the Federal Government, because Government funded patients form a massive population of less-than-desirable patients based solely on their funding levels and accompanying red tape.

In San Diego, a true public/private partnership has been forged between county government and the 22 private, nonprofit community clinics. But only three of these clinics receive Federal support—the rest operate on a piecemeal assortment of grants and contracts that continually threaten their stability and hinder their growth. Through OBRA 89, the Federal Government has created a category of community clinics that are being referred to as Community Health Center "look alikes." They are organizations that mirror federally qualified health centers, but do not receive Federal funding. Their mission is to meet access needs so that poor people can get primary care at the very least.

We urge the Federal Government to incorporate these look alikes in the funding allocation for Community and Migrant Health Centers in order to insure their survival and guarantee access to primary care—not only for the 26 percent of our population without insurance, but also for the 25 percent who are underinsured. Failure to fund services for this segment of our society jeopardizes the availability of services for everyone, when underfunding forces elimination of some specialty services, or, worse yet, the closure of entire facilities or programs—just as the comprehensive perinatal program for poor women was threatened here in our community only last week.

The counties in California can no longer bear this burden alone. The State is in no financial position to share this burden. It is high time that we acknowledge every person's right to care when they are ill, and the right to those preventive services that will help keep them well and productive. Only the Federal Government can address this problem in a concerted manner, and the mechanism is in place to do this—provide funding for the Community Health Center "look alikes" through the Public Health Service.

[The prepared statement of Mr. Arce may be found at end of hearing.]

Mrs. BOXER. Thank you very much, Mr. Arce. Dr. Stennes.

STATEMENT OF DR. RICHARD STENNES, PHYSICIAN, SAN DIEGO COUNTY

Dr. STENNES. Congresswoman Boxer and Congressman Bates, it is a pleasure to be here this morning and have the opportunity to address you. I have prepared some written remarks, and you can read those. And while my friend Mr. Simms over here was being so eloquent, I prepared a few notes to amplify, so I would like to highlight a few of the things, if I may, in my written remarks.

There are four parts. One is the remarks I prepared for today. And then, by way of expansion, I have included some other communiques. One is to a Dr. Richards, who happens to be in the AMA House of Delegates. Sits next to me, and wanted a little report on the problems with backup. And so, I have given you that particular letter. There is a letter to Senator Bentsen, Representatives Waxman and Stark, talking about some of my concerns over the recent budget debates, and particularly with respect to Medicare, and I would call that to your attention. And then, another attachment on the definition of a disproportionate share provider.

I am here to speak as an emergency physician. I have been one of those for 19 years here in San Diego County. I have also been on the board of directors of a disproportionate share hospital in a national city, and I have been president of the American College of Emergency Physicians some 5 years ago, so I have somewhat of a national perspective.

And Lucy Killea this morning reminded me that I am also a jailhouse physician, by virtue of county contracts at the moment, providing care for some of the ladies that she was talking about this morning, out at Las Colinas.

First, I am happy to report this morning, in my checking of various emergency departments, that things are in pretty good shape today in San Diego County. There are no hospitals on by-pass this morning, or last night, or in the last few days. And I'll come back more to San Diego, if I may, because nobody realizes in San Diego that we have got a problem, or are getting close to a problem. And if you only look at our audience, you can begin to see that they do not know that we have a problem.

Mrs. BOXER. What do you mean—hospitals on by-pass? Could you explain that to us?

Dr. STENNES. Yes, I will. Let me expand just a little bit on Los Angeles. Because you are talking about a national perspective, I made a few calls this morning. I called some friends in Los Ange-

les, Chicago, New York, and Houston, to find out what the status was in their emergency departments there.

And starting, with Los Angeles, I called Big County USC this morning, and found that as of 2330 last night, eight hospitals in Los Angeles County were on by-pass. That is, close to saturation, because there were no beds available in the emergency department to put another patient. Or, no beds in the hospital in which to transfer patients out of the emergency department to beds, in order to open more in the emergency department. That is basically what I am talking about with respect to saturation.

All the big ones—Harbor-UCLA, Oliview, UCLA, Martin Luther King Drew were all closed last night, as many of them are regularly. Martin Luther King Drew lives in closure nearly in perpetuity, because they are full all the time. Every now and then, they transfer patients out that have been there 3 or 4 days to other facilities for admission, because there is just no way to get them in.

At Harbor, for instance, at the meeting at which I met you a month ago, Women in Emergency Medicine, Dr. Hockberger was talking about one of the problems that they have with respect to saturation, at the moment. Once a diagnosis of appendicitis is made on you in the emergency department, 40 percent of the patients will rupture their appendix before a surgical suite becomes available to operate on them. Waiting times are now measured in hours, and they go home and come back, sort of like they did back in my old Navy days. They come back the next day to get in line again. It is an incredible problem, and getting worse.

Now, with respect to other parts of the country you probably know about New York. At the moment, many hospitals patients, 14 of them, are lined up waiting for admission, having gone through the admission process. They are now getting fed and treated in the "wonderful milieu" of the emergency department, which is not exactly a good place for most people who have admitting diagnoses. Twenty-five percent of those people have AIDS. Which is an alarming statistic. I do not think it is that high here in San Diego.

To come back again to San Diego, and what is going on here. You have heard a little bit about the trauma centers and Mr. Simms has addressed that issue, and Supervisor Williams. We, indeed, have a very good trauma system in this county. A bunch of them happen to be in the central city, and perhaps not distributed properly, but in the days of modern conveyances, helicopters, and so on, transport does not seem to be a major issue. So we have done well on that.

We happen to be blessed by an extraordinary number of very good emergency departments, and extraordinarily well qualified emergency physicians, credentialed by the American Board of Emergency Medicine. So we are well blessed in that respect. But we do have saturation problems, and we are heading into a season in which that is going to be a bigger issue.

Last Christmas, for instance, we were transferring patients from National City to Encinitas, because there were no beds. Much of the time, and I happen to be in a hospital—I serve three in this county in our group—in which, very often, the emergency department is full. There are no beds to put patients in. There are no critical care beds to put them in. Census in the hospital is not that

high, but you cannot put a critical emergency department patient into an OB bed, or a Peds bed, or a Medicine bed. They have to go to a critical care unit. And therein lies much of the problem with access, in this particular county, and in much of the rest of the country. There are just no critical care beds available to put these patients. And that contributes mightily to the ED overload problem.

There are other reasons why overload occurs, as well. We happen to be, in the emergency departments, what you might call the ultimate safety net. I heard the President talk about safety nets not to long ago, and we happen to be it. There are some 37 million Americans uninsured. They happen to have the emergency department as their access point for health care.

A major problem, and Mr. Simms pointed it out earlier today, is unreimbursed care. And I would call your attention to the last page of that item I gave you. It talks about what is the definition of a disproportionate share provider and we happen to be one of those. In our emergency department, 68.7 percent of the patients who register are unemployed. Thirty-eight percent are Medi-Cal beneficiaries, and we collect 23 percent of charges on that particular group. One in ten of those people get admitted on a nationwide basis. Eighteen percent are uninsured—with a 14-percent collection rate. Twelve percent are Medicare and we collect 43 percent on those; 7 percent are medically indigent adults, and they give us a 28-percent collection rate.

So if you add up that bunch, you will see that our collection rate is not real good—Medicare being the best of the bunch at 48 percent. So we can transfer a little bit of the money out of the Medicare to cover some of the Medi-Cal, because we will lose 36 cents—after billing, insurance, and typing costs—on a Medi-Cal visit in the emergency department. Saying nothing about the physician or the other cost. Mr. Simms addressed this particular issue. The fact that that is a problem for us, of course, and Mr. Bates is an expert in this particular area, because the hospitals in his district happen to all be, I think, disproportionate share hospitals. There are some north of Interstate 8 that know a little bit about this, but do not have the same problem.

I was at a hospital referenced earlier, San Diego Physicians, and now San Diego General for 14 years from the day it opened in 1973. I left about 4 years ago, because in a good month, we had a 21 percent collection rate. I left because I could not pay doctors under that system. Furthermore, when UCSD and other hospitals started stopping taking transfers, I had to leave because there was no one to care for the patients and nowhere to send them. The person who now succeeded me, as of yesterday has given his 30 day notice in that particular hospital as well, because he just cannot, without adequate backup, continue the broad care that he needs to do. Furthermore, he has not been paid in a couple of months.

The problem that we have with disproportionate share, and these items I have just talked about, is reflected in all the other doctors who take backup, and you have got to have backup specialists to function in an emergency department. You come in with an ectopic pregnancy. I could make a diagnosis, but I cannot take it out. I can do a lot of medical things. I can treat your heart attack with the

new juices and so on even though it may be suboptimal in the ED setting but I cannot go to the operating room with these people.

Let me give you an example of obstetrics. We had eight obstetricians in one of the hospitals that I functioned in in East San Diego County. Only one of the obstetricians took backup calls in the emergency department. So the Medical Executive Committee said, let us mandate that all of the obstetricians on the staff have to take calls. They all then quit. Closed the department. Now the emergency department has become the delivery center for those women who do show up in labor.

Another hospital I am very familiar with decided to go mandatory across the board for all doctors. That is, you have to take backup call if you want to be on the staff. Forty-three percent resigned in three days. We would have had no staff left if we had not rescinded that, and for understandable reasons, many of them relating to hassle factors and reimbursement factors that Mr. Simms talked about.

With respect to orthopedics, we have less orthopedic surgeons today where I work in the southside of San Diego than there were 19 years ago when I went into practice. One died, one retired, one is partially retired, and one new one came 13 years ago. With all the orthopedists in this county, you would think there would be a different distribution. And why are they not in south San Diego County? Well, part of the problem is, you cannot force them to practice in an area in which they cannot even collect enough money to pay their nursing staff and overhead, let alone taking something home to the "significant other," who wonders about why you are going out in the middle of the night to do things that create hassle and aggravation and malpractice and do not seem to pay you anything.

And then, of course, the Federal Government has been very helpful in many respects, and less than helpful in some others. They have come along with some Federal mandates, outlined first in COBRA, very appropriately called. In that particular bit of legislation, you in Congress came up with some new mandates that said, you were going to fix the problem. You mandated that every patient who presents to the emergency department has got to be seen. Well, we do not have a problem with that within our specialty, the American College of Emergency Physicians, because we do believe that the right to access emergency health care is something every citizen has to have, and they do have. So we, work under that safety net, and see them all. And we will continue to do that as long as we are able.

However, when the Federal Government mandates that physicians are going to see every person who presents to the hospital emergency department, it seems to me that you have to make provision to pay for it. Thirty-seven million Americans are uninsured, and they get that access, as well as Medi-Cal, and all the others who really cannot go anywhere else. So you mandate that we are going to see all. What does it really mean? Well, let me give you an example.

You get a rash, you go to the drugstore and you want to buy some Benadryl. You have no money, and so you just take it. And you are heading out the door and they call the police. And then,

you haul out your gun. In the first case, stealing the Benadryl which is a misdemeanor will not get you into jail, because the jail is full. However, the armed robbery will.

Now, if you come to the emergency department with your rash, the doctor goes to jail if he does not give you the Benadryl. Somehow, there is a problem with this particular system. And you wonder why physicians are increasingly reluctant or unable to be available to take care of patients in the emergency setting, or take backup, or take patients in their office on referral from the ED.

What does the future hold? Well, the demand for service is not going to go down. We have an increasingly elderly population. I have an enclosure that talks about that. By the time I retire, there will be two workers to support every one retired Social Security recipient. Thirty-three percent of the population will be over 65, of the group between 15 and 65, who are going to support them. So the demand is going to go up. These people get sick—sicker than the younger population. There will be new technologies. They will cost more, although I think they may save money, because they treat illness earlier and less expensively, for they keep people alive for more years to get sick again.

We are certainly going to have to see more dollars into the system. Vastly more dollars. Costs are continuing to go up. I mean, the nursing salaries go up. Malpractice goes up. About 4 years ago, we paid about $30,000 a year for malpractice. This year, it will be just under $500,000 for our group, and we have never had a settlement in 19 years of practice. So those costs will continue to go up for providing the service, and something has got to go up in terms of reimbursement.

I think you need to keep in mind, in all of your discussions and deliberations, an immutable law that Congress seems to disregard from time to time. And that is, that the cost is going to equal the price times the volume. At the moment, seemingly, all the attention is on price and cost. Not much talk about the volume. We have to do something to try to contain the volume part. I will make some comments about that and some of them are, perhaps, alarming and argumentative, but something that our society is going to have to discuss in a lot of detail.

The first one is the right to die. Every day in our emergency departments—we happen to be surrounded by nursing homes—people come in who are probably not aware of their surroundings and have not been for some time. They may not have a family anywhere, either. But they come in and they would die if we would let them. However, we are not so sure that that is what the family wants. And I do not want to have a visit from an attorney. So you intubate them and give them a little squirt of Rocephin or some other antibiotics, a little oxygen, and in another day or so they go back to the nursing home after several thousand dollars worth of expenses. There are many examples like that, that we need to address in our society, when many of these people want to die, and they tell you that. But you just cannot do it. We are going to see, I suspect, a lot of discussion on that, because we spend an enormous amount of money in the last 10 days of life. If only we could just identify when those 10 days begin.

Another issue that is going to need attention is transplants. We can spend $400,000 giving somebody a new liver. They may live, or they may not live. Meanwhile, a thousand kids could have gotten immunizations and well baby checks, and have been a healthy adult in a society, with a lot less long term costs on care than what we see today. Mr. Simms and Mr. Arce addressed those issues of no prenatal care and some of the problems there.

Can we afford in our society—do we have the resources—to spend that kind of money on those kinds of technologies for such limited numbers of people who would be benefitted by it? We have got to look at the Kitzhaber model, which I am sure you all heard about. Senator Kitzhaber, an emergency physician and president of the Oregon State Senate, has been actively looking at how we can try to rationally apply limited resources to the health care area. What is basic, adequate health care? How do you define it? We need to do that.

And then, we have got to prioritize. There are things that we have to do, the highest priority down to the lower priority. Note the amount of money that we are going to spend. Then when you run out of money, stop doing those transplants, or whatever it is, we are going to stop doing, because we cannot pay for it all. Our society has an insatiable appetite, and we can never satisfy it all.

We have got to do something about the current tort system. I mean, every day when you go to work, you are concerned about it. For every patient who goes home from the emergency department, the last thing you think about is, have I done everything I need to do for this patient? Which is a good thought. We need to keep that in mind. But have I done everything so that I can defend myself when and if there is an untoward event—a maloccurrence, for most of the time it is not malpractice, it is a maloccurrence. We have got to look at the tort system that drives defensive medicine as well as makes it very uncomfortable to practice.

We have a fun to fear equation in everything that we do. And physicians are on a fun to fear equation as well. And the practice is getting uncomfortably close to the fear part. As a result, physicians are leaving practice, or not going into medical schools.

We are going to have to look, and this is an issue that was addressed or touched on in the introductory remarks, greater participation by Medicare beneficiaries in the cost of their care. At the moment, I am advised that for about $40 a month, you get a $430 payment by the Federal Government to an HMO to take care of you (Los Angeles). There is a discrepancy here, and somebody is going to have to make it up. I submit, as I have in my written testimony, that there are a good deal of Americans who are elderly who can afford to pay more for their health care than they currently are. There is not going to be enough money printed, or taxable, in the future, to keep going the way we are going now. It has got to change. And that is addressed in my letter to Senator Bentsen and the other chairpersons.

Your Task Force is appropriately named—the Task Force on Human Resources, because human resources is what this is all about, to a large degree. You have to have physicians, nurses and other health administrators, to take care of these patients, and, of

course, humans are our major resource in this country, and we need to take care of them well.

The emergency physicians who are going to be the ultimate safety net, and continue to be the safety net, do have a problem. We cannot continue to function in emergency departments if we are going to be mandated to see patients if there is not going to be enough money to pay for it. We are going to see more and more limited access, as emergency departments have to close. We danced around this issue about a year ago at a major provider in the south San Diego County having to close. The medical staff voted to do it. The hospital did not at that particular juncture, and we continue to try to march along as the only provider in a very large area. And Mr. Bates is quite familiar with that particular problem.

In 1992, I expect that health care is going to be a much bigger issue. We have not heard much from the last president or the current president about health care issues. I expect by 1992 it is going to be a major issue, because more emergency departments will have closed. Half the trauma centers in Los Angeles have already closed. Some here in San Diego may, one day, close as well. We do not have the problem here in San Diego that the rest of the country does in many ways, but it is going to get worse.

So I expect that we are going to see something dramatic. We are going to see the RBRBS implemented by 1992. You people may do what you did with DRGs for hospitals, and that is, in a few hours or days, radically change the hospital side of the equation. You are probably going to do something similar on the physician side. My only caution to you is that you do not do something that makes it worse, if that is possible. Mandate that physicians have to see people and physicians will move out of the community, or not move in, as they cannot be made to stay in a situation in which they do not bring home the bacon, so to speak. Somehow one has got to be paid adequately for services rendered as Mr. Simms eloquently outlined.

Medi-Cal in its current state is totally unacceptable. Medicare paperwork hassles are so bad, that many physicians do not even want to see Medicare patients any more. Physicians do not want to take patients on referral from our emergency departments. In years past, that was how you built your practice. We would send patients to a private office for followup. Many physicians do not want them any more. And if you look at my list, here, 68 percent of the people who register in our emergency department are unemployed. And nearly every patient I can send to an office has no money, because you also created incentives for HMO's and IPA's and ambulatory surgery centers and they take all the funded patients. Who does it leave with all the rest? And where can they go? They go to the hospital emergency department.

I am pleased to be there. I like being an emergency physician, and I hope to be one for some time. And I hope that you people are going to help make it happen. Thank you.

[The prepared statement of Dr. Stennes may be found at end of hearing.]

Mrs. Boxer. Thank you, Dr. Stennes, very, very much. I have to tell you, I have had six hearings so far, and I have a couple more left before the end of the year. And I am just saying this to you,

that I think that this panel has been eloquent. And I think the testimony has been extraordinary, both in touching on the universal subjects and the ethics that we have to deal with, as well as giving us a picture of what San Diego is like.

I would like to say to Mr. Simms, I would very much like, along with Mr. Bates, to put your testimony into the Congressional Record when I get back, for the new Congress, assuming all is well and I am back there. I would like to do that with Mr. Bates. Because I think that your testimony was so clear, and it was so sharp. It delineated the problems, not only that you are facing here, but that I am hearing over and over again, as I go around the country.

So if Mr. Bates agrees, then we will both do that at the start of the new Congress.

Let me just say, I want to make sure I heard correctly the status of health care in San Diego County. Because if I heard it right, then I think you are in crisis, and I do not want to overstate it. But is Mr. Arce correct, Mr. Simms, that 51 percent of the people in this county are either uninsured or underinsured? He said 25 percent were uninsured, and 26 percent were underinsured. Are those figures that you subscribe to as well? Speak into the microphone, if you can.

Mr. SIMMS. It has now been confirmed that, indeed, 26.2 percent of San Diego residents are without insurance. From our own experience, at least 20 percent, and perhaps as many as 25 percent, are underinsured—are carrying significant burdens that represent a barrier to their access. So I would, absolutely, concur with Mr. Arce's statement.

Mrs. BOXER. Well, that is an extraordinary statistic here. Am I also correct, Dr. Stennes, that you said that in some emergency rooms, and I was not clear whether it was here or not, but in southern California in any event, that there are people, for example, with appendicitis, who come in and are told to leave and come back later?

Dr. STENNES. No; the, for instance is they have public hospitals or county hospitals in Los Angeles County, which we do not have here in this particular county.

Mrs. BOXER. Right.

Dr. STENNES. There are a preponderance of indigents, obviously, that go there. If you talk about Harbor UCLA, which is in the Torrance, Long Beach area, a major provider, their waiting times for people that walk into the emergency department get into being hours and days, and, of course, if it is not too severe, they may go home and come back the next day, waiting to get in to be seen.

A person who is seen, I mean, they may sit there with abdominal pain for a long time, and get a hotter and hotter appendix. The diagnosis is now made. Now, we need a surgeon. They are all tied up with trauma. The surgery suites are full. And the statistic recently given me is that from the time that I make the diagnosis of appendicitis, until we take it out, 40 percent will rupture, just waiting for an operative suite to become available. And that is because of the level of indigent care.

This morning, when I tried to call the MAC, the communications control at Los Angeles County, you cannot get through, the phones are busy, because every hospital around, other than the ones I

mentioned which are closed, are trying to call and transfer their indigents and county-responsible patients to them.

Mrs. BOXER. So what you were focusing on for us is to explain to us in a very clear way what happens when the emergency room is used as a first line of health care. Because, people go there with an abdominal pain. Then, they have to wait, because there are more severe things happening. People with gunshot wounds, and automobile accidents, et cetera. So by the time they are diagnosed, 40 percent of these appendicitis attacks, for example, could wind up in a rupture—which, as I understand, is very dangerous. And I am sure it is a much more complicated surgery; is that correct?

Dr. STENNES. That is correct. And that is an example in one hospital, but it is an example of many of the problems. And it is not just that you have got an enormous amount of trauma and other things that are coming in, you do. But you have a lot of other people who really have no other access. There is no place for the indigent people to go to get care. And so, they wait—they either come to the emergency department, where we really do not need to be seeing that type. Or, they wait until they get sick enough to really justify it.

And one of the statistics I have in my note there, and we have done this now in a million visits in 20 states—1 in 10 Medi-Cal visits, nationwide, gets admitted to the hospital upon visits to the emergency department. One in two—48 percent of the Medicare population—gets admitted when they come to the emergency department. So you get an idea of the severity of illness, and who utilizes—or the difference in utilization of emergency departments by the elderly. They usually all have doctors. They can go to doctors' offices.

Mrs. BOXER. Right.

Dr. STENNES. When they are really sick, they come in by ambulance, paramedics and so on. The other end of the spectrum, the indigent end, on the other hand, has no place to go. And so they very often come to the emergency department. Much of our overcrowding problem, in New York, in Chicago, in Los Angeles, in the county hospitals, much of the problem has to do with over-crowding by patients who could be cared for in a clinic, if there was one available. Or better yet, if they had access to more public health services and immunizations and all the rest in their infancy, that would be the case.

I mentioned earlier about deliveries in emergency departments that we do. Every one of them is a high-risk mother. They are all on coke, or heroin, or something. Otherwise they have a doctor. We only see the ones that do not. It is a real bad situation.

Mrs. BOXER. So the picture you are painting, and I just want to make sure I understand it, because I have heard it now in several places, is that the uninsured people use the emergency rooms as their first line of care——

Dr. STENNES. Very often.

Mrs. BOXER [continuing]. Very often. And——

Dr. STENNES. Only line.

Mrs. BOXER [continuing]. As their only line of access. And that you are not getting reimbursement for these. And you are suggesting to us that in the coming year or two, we may see a complete

breakdown of the system, if these emergency rooms decide to throw up their hands and say, we cannot handle it any more. And then, Congress is going to have to deal with a situation—I mean, people will be dying on the streets, literally, if we do not have a replacement for this first line or only line of care. That is basically what you are saying?

Dr. STENNES. I think that is a good synopsis. And most of the public currently has not been impacted. Important people, so to speak——

Mrs. BOXER. I understand.

Dr. STENNES [continuing]. Have not really been hurt by this system. But the problem is, when you have an emergency department full, it is full to everyone, not just the indigents or the uninsured. It is full to anybody that happens to come by and need care. And when more and more people, who call and write to you, and campaign contributors, and all the rest, really get into this, then we will probably see—and I hate to be cynical about this sort of thing, but I think that is where it is going to have to go. It is going to have to get worse. And it will get worse, before it gets much better. There is no question about it.

I suspect that another hospital in town, previously referenced, will probably close down. It effectively has a very difficult time trying to operate now. Many years ago, I was at another one down here, and we closed the emergency department and made it an urgent care center. Because everybody who came in by emergency department was totally indigent, and the hospital could not survive. So that one happened in this county years ago.

Mrs. BOXER. Well, the reason we are holding this hearing, and the reason Congressman Bates and I are here, is because we do not want to wait until people call us and say, we cannot get in. We understand the issue right now.

Mr. Simms, again, as I take these hearings around, I am coming to the conclusion that Medi-Cal—and, I may be overstating it, or dramatizing it, but it could be called a fraud. Because, I had a physician come before us in Fresno, who assisted in a birth in the middle of the night. A very complicated—one of these emergency type of premature births, and got reimbursed $16. And if that is true, you would say that that is accurate?

Mr. SIMMS. Yes.

Mrs. BOXER. I mean, he said that. Then, I do not know that we have a Medi-Cal system here, and I wonder if you could comment?

Mr. SIMMS. It seems to me that we do not have a system of any kind. It is a nonsystem. It is little parts that have never been drawn together. And that is an important diagnostic to understand. I mean, we are social architects. The people of this country ask us to spend their money prudently. Sixty percent of the visits to these emergency rooms were not emergency in nature, and therefore, could have been provided elsewhere.

Now, an average visit to an emergency room is a $200 item, at a minimum. An average visit at a neighborhood health center or community clinic is a $70 visit, on the average. So in other words, that is roughly two-thirds of the $200 visit that could have been provided as effectively, cheaper. This is the kind of organization, it seems to me, that we have got to first design the model.

There has got to be adequate access at neighborhood health centers. Now, patients vote with their feet. And so, to some extent, it is important that access to care be part of a public education program where patients know what to do.

In this community, we recently lost one of our esteemed educators, by well-intentioned, but ill-informed Good Samaritans, who took him, having received a major stab wound, directly to an emergency room that was outside the trauma system, was not a trauma facility. And his chances for survival would have been significantly increased, had the person dialed 911 and gotten this critically injured person into the trauma system.

Similarly, patients wait to go the emergency room until a minor problem becomes a major problem when, if we educated them effectively—and, I say, part of the burden is on us—they would reach out to these clinics, identify them, and use them as the front line of defense. The front line is the neighborhood clinic. We have the thing turned around, where the front line is the emergency room.

Mrs. BOXER. Right.

Mr. SIMMS. So that is part of the design model, it seems to me, that Congress needs to adopt in this coming decade. My last comment has to do with the issue of incentives. It has been said that systems of people perform in a way that the structure provides the incentive for the behavior. In other words, poor structure begets a poor incentive. And the poor incentive generates poor outcome. So now this $16 payment to the physician in Fresno is a poor outcome. If we go back and we look at it, it is the structure that all of a sudden said it was okay to pay him $16, for what must have been $500 or $600 in value. The recognition of incentives, in all of this, it seems to me, becomes an important legislative concept for Congress to incorporate into health policy. I will give you one example, and then I will be quiet.

Let us suppose an individual took care of his health. He started out at 300 pounds, and he wound up, all of a sudden at 250, and his health utilization, or her health utilization went down. In other words, he or she is beginning to actively take some better control over their health behavior, and that is a good thing. That is a good thing for the Federal budget. Nobody says thank you to that person. Nobody recognizes that that worth generates a value, and would tend to tie us all together.

If somebody were to send him a $5 bill, or a $50 bill, and say, we noted over the last 2 years you have not used our public health system, and that is important. You are maintaining your health and we want you to continue to do that. And here is a little token to continue to incentivize you, it would seem to me that that would be the kind of partnership that we have extended, not only to the providers, but to the patients. The patients are the ones who can become more active partners, it seems to me.

Some HMO's have recognized this, but we have not had yet the resources. I mean, this takes some momentum, to try to build these kinds of systems. We are too busy sliding backwards.

Mrs. BOXER. I understand.

Dr. STENNES. Can I respond to the comment that Mr. Simms made? And I want you to be understanding of this. He talks about the $210 versus the $70, and those are real numbers. Except, it

very often reflects charges, and in this system, charges bear no connection with payments, other than they are always more than payments, never the other way around. In our particular system, as I pointed out here in these notes, about 40 percent of our charges result in payments.

So in actual fact in the emergency department, if we got paid for every unit of service we provide, we could charge less than half of what we currently charge. But you have got to charge these people, and the ones who really get hit today are the ones that are insured with a $1,000 deductible, have not met it, come to the emergency department, get hit with a big bill. Because, I have got to tap this person and say, excuse me, would you mind paying, I need $30 for this one here, and $30 for that one there to cover just the insurance and the other costs, and that is why the costs go up. So there is a lot of cost shifting that occurs. If that did not happen, the costs will be dramatically less. The differential would not be as big, although it will always be there, because the intensity of care, the technology of the personnel and so on, are a problem.

And the last thing, with respect to the back up. And I touched upon this earlier. The law mandates now you have to have this list of physicians available, and we should, and we must. But what if you do not? The hospitals that do not, or cannot, provide those lists, and have to go out and hire or pay or somehow provide incentives, are the least able to do it. And the hospitals that have a lot of staff—160 obstetricians, one night out of 160 on call is not a big deal. For my hospital, it is one night and four, and that is a big deal.

We have to somehow change that incentive system around, or the hospitals in Mr. Bates' district, and similar districts, which are the disproportionate share types, for the most part, will close. And they will go out of business, and none of the other hospitals want that to happen.

Mrs. BOXER. Right, of course not. Congressman Bates?

Mr. BATES. Thank you very much. I commend the panel on their very valuable testimony. And it seems to me, as trying to struggle with these problems and how to solve them, it seems to me that the major underlying problem is inadequate resources.

It also strikes me, for whatever reason, that the forces that play in the political system, have not seen fit to find these resources, or reorder priorities, or somehow address the financial underfunding. While I am committed to continuing to do that, it seems to me that most of my interaction with cities, counties, programs, projects, physicians—and, just as an aside, I sit on the Health and Environment Subcommittee—so, I am placed in a position, I think, to be helpful.

Congresswoman Boxer, chairing this Human Resources Task Force for the Budget Committee, is also similarly well placed to address these problems. But it seems to me the life of a legislator is hectic, time consuming, other problems, other areas, other demands on our time. That if we could link your agenda with ours, in more activity focusing on a legislative agenda to deal with some of the things that you pointed out, that would make a more cost effective system, we could shift some of those costs within the system, to maybe try and address those needs. And I think, you know, some

that are just so striking and obvious, that they beg for an explanation, why there is not something being done? And I would like to do that, in working with Congresswoman Boxer. I would like to have the legislative agenda that you have helped identify today, and will help us draft that legislation.

The time for payment, for example, maybe we have done that when Federal contract, where the same problem occurred. That people were going 6 months without getting paid, and so we came in, where now contracts have to be paid within a certain period. And that may not have solved all the problem. But it seems to me on this payment question, we have got to deal with that with a legislative proposal.

The idea of the forms. I have not filled out one of those forms. I probably should have to. But from what you have indicated, there needs to be some changes there, that should, with all the people working in the bureaucracy, that we would have devised a simpler form. But if they have not, then maybe we will.

The right to die is an issue that for years has been begging to be addressed, I think, for a number of reasons, as you pointed out, Dr. Stennes. And I would like to see if some cases—the sort of anecdotal stories that can be told, that can justify and make this argument to the American people. But what we are going to do is begin to fashion legislation in that area, that deals with that problem.

Defensive medicine—again, help is needed. And probably, those who have suffered the losses in the system, that really was not fair. On corollary, is also the problem with the doctors who do make mistakes, legitimate mistakes, and how that system has been set up. Now, it seems to me that computer based now is treating every filing or allegation as if—when the record is brought up—as if that, in fact, were accurate. And when it is not the case, and then it sets off a whole series. So instead of the purpose for which it is intended, it has almost created another problem. I would like to see something on that.

And then, the uncompensated care question, as it relates to emergency rooms, which are, I think, interrelated, are all questions that I think we may be able, by fashioning and working, instead of seeking more funding, maybe fashioning legislative proposals that will shift funds, or try and use funds better that we do have. Though, I think we need to make the commitment that we are going to have to spend more on health care in any event.

But I am really pleased with the level of competence and information and knowledge that you have. And I think it is a resource that cannot be wasted, in solving these problems that are really of emergency nature in San Diego County. Thank you.

Mrs. BOXER. Thank you, Congressman. You should be proud of these people. I would just close off this panel by quoting one sentence from Mr. Arce's testimony, in which he says, "It is high time that we acknowledge every person's right to care when they are ill, and the right to those preventive services that will keep them well and productive." That is the simplest, most direct way of putting it. And we have to be sure that the people within the system that are doing this good work do not leave the system, otherwise we will not have any system.

You have brought that out in a very direct way, and I compliment you for it, because you could be more angry. And I think you have made the point that we are at the brink of a serious disintegration of a health care system that has sort of been pasted together, piece by piece. It is really time that we do look at it as a whole. I think that time is coming. And unfortunately, you are in it right now while it is on the downturn. Until we recognize how serious the problem is, it is going to continue.

But Congressman Bates has offered to work on legislation with me, and I look forward to that. Thank you all. You have been just terrific. Thank you all very much.

I would call forward the next panel. Lisa Firth, regional coordinator, Regional Perinatal System; Judy Beck, R.N., nursing supervisor, San Diego City Schools; Dr. Nancy Bowen, chief, maternal and child health, San Diego County; Winnie Willis, Ph.D., associate professor, Maternal and Child Health Division, San Diego State University; Blair Sadler, president and CEO, Children's Hospital and Health Center.

There is a reason for the way we have divided these panels, Congressman Bates. The first one being the electeds. The second being an overview; the third being children; and the last being the elderly. This is the children's panel.

Congressman Bates has an appointment so he is going to leave us, but we are going to get together and go over the testimony of this panel and the one after.

Congressman, I really want to thank you for taking time out. I know it is a hectic time for you down here, and I appreciate your joining me.

Mr. BATES. Thank you.

Mrs. BOXER. We will start right out with Lisa Firth. Again, what I would like is if you could summarize in 5 to 7 minutes, and then, it will leave us time for questions.

If Ms. Firth does not mind, we will be glad to call on Blair Sadler, president and CEO, Children's Hospital and Health Center. And when you finish your testimony, if I have any questions, I will ask, and then you can go catch your plane.

Mr. SADLER. Thank you.

Mrs. BOXER. We are glad you could be with us today.

Mr. SADLER. Is this on?

Mrs. BOXER. Yes; you have to just speak loud.

Mr. SADLER. Great. Thank you.

STATEMENT OF BLAIR L. SADLER, PRESIDENT AND CEO, CHILDREN'S HOSPITAL AND HEALTH CENTER

Mr. SADLER. It is an honor to be here and, in a few minutes, to give you a snapshot of some of the things happening to children from my perspective. I applaud your providing a forum to discuss these vitally important issues.

Today at Children's Hospital, there are about 140 inpatients ranging from somebody who nearly drowned, a 2-pound baby born prematurely with cocaine in his system, and another 115 kids being treated in our outpatient clinic.

We have a 59-bed convalescent hospital on our campus. It is the only kind in the Western United States. That is 99 percent Medi-Cal and the waiting list is over 5 years. And these are kids, unlike our acute care hospital, who have major head injuries or trauma, that will never recover and need support.

Today, in San Diego, which we like to call America's finest city, 173 children will be reported as abused or neglected——

Mrs. BOXER. How many? I'm sorry.

Mr. SADLER. Today, 173.

Mrs. BOXER. Today?

Mr. SADLER. Today. Eleven babies will be born with alcohol or drugs in their systems; eight San Diego teenagers will get pregnant; 10 women in San Diego will give birth without receiving any prenatal care at all.

While these facts are merely a snapshot, of what is happening across the Nation, the status of child health in this country is critical, and the diagnosis for the future is poor.

What a legacy, we are about to leave to our next generation, unless we make some fundamental changes. We have made substantial improvements in health care in this country, and including the child health of this country for the last 50 years, until the past 10 years.

So it was not surprising that in 1980, when the Surgeon General said, here are the goals for the United States of 1990. There were 16 goals, and we would move ahead on them. And yet, during the 1980's, we failed to meet nearly all of those standards. And a lot of this is in the testimony, Mrs. Boxer. In fact, with many of those standards, we are actually worse off. And it is now clear to me that the 1980's will be regarded by many as the decade America forgot its children.

Trickle-down economics does not trickle down to poor children. The number of uninsured children, nationwide, has increased 13 percent in the last 5 years. Babies whose parents have no health insurance are about 30 percent more likely than those from insured families, to die or be seriously ill at birth. Forty thousand babies born in the United States this year will die before their first birthday, as you have heard from other testimony. As unbelievable as it may seem, a baby born in Spain or Singapore, or 20 other countries, has a better chance of reaching their first birthday, than a baby born this year in San Diego.

For those who do survive, immunization rates for children under 2 years are actually declining. Only 60 percent of children under 4 have received the complete basic series of immunizations. And you have already heard today the cost effectiveness of that. It is just staggering, that we are not allowing that to move forward.

So we are actually reversing the progress we made over a 50-year period. Indeed, we are inviting these kinds of deaths. In San Diego Children's Hospital, we had two children die within the last 8 months—two children die of complications from measles. These are the first two measles-related deaths in San Diego County in 19 years. And these are kids who were never immunized. They were poor. The cost of treating those kids for 5 or 6 weeks is obviously several thousand dollars. It gets back to another point you heard

this morning. I am just trying to paint some specific examples of how serious this is.

The Surgeon General predicted that child abuse would decline during the decade by 25 percent. And between 1985 and 1986 alone, it increased 55 percent. Nationally, injuries, accidental or otherwise—is now the leading cause of death in kids from age 1 to 14.

Teenage suicide is now the third leading cause of death for kids 15 and older, with deaths more than doubling since 1960. One young person in this Nation commits suicide every hour and 38 minutes. We like to think that happens only elsewhere, but this is happening right in our hometown.

This year, 3,000 San Diego teenagers will have babies of their own; 3,000 San Diego teenagers. Often, these babies are born weighing less than a Sunday newspaper. And they are dependent on newborn intensive care units to survive. California, by the way, has the very dubious title, as the Golden State. We have the second highest adolescent pregnancy rate in the Nation.

Another critical fact. This year, 4,000 San Diego babies will be born with alcohol, marijuana, cocaine, heroin or crystal meth in their system.

Mrs. BOXER. How many?

Mr. SADLER. 4,000 in San Diego, alone. It is estimated that one of every 10 pregnant women in San Diego abuses alcohol or drugs. If the baby does not die from the drugs, they may be faced with brain damage. And the cost of treatment for an infant's narcotic withdrawal can top $30,000. Costs for the special services required to treat fetal alcohol syndrome, over a lifetime, can be $400,000. Piggybacking on a point you heard earlier about our incentives are backwards. These babies are born addicted. They did not choose their parents. They never had a chance to "just say no."

In terms of child abuse and neglect, last year nearly 68,000 calls were referred to San Diego's Child Protective Services via the child abuse hotline. That is 68,000 calls in one year. This represents a 450 percent increase since 1982.

On a more personal note, it is hard not to be affected, when you read about two little brothers being beaten and abandoned. In this particular case at Children's, we could not even tell they were twins at first—they were so badly beaten. It is very hard to read about, or hear about a badly bruised toddler with rope burns on his legs. An 18 month old with a broken right arm and a broken left leg, which had been broken and unreported for 6 weeks, before he was brought to Children's by Life Flight, unconscious and near death.

In 1987 alone, 27 San Diego children under the age of 4 died from confirmed or suspected child abuse. Intentional abuse is the one that I have trouble not getting emotional about, so if I do a couple of times today, I apologize. As a parent myself, it is hard to even read some of these statistics.

We talked about the "no-care" problem, and you heard about that this morning. Another key thing—the fact that these are just babies.

Between the ages of 14 and 17, one out of five kids are problem drinkers. Last year in San Diego County, 66 percent of high school seniors—66 percent—said they were regular alcohol users. Fifty-

three percent had used marijuana, and 19 percent had used cocaine. Incredibly, today, the average age—the average age—for first time drug use, is 13. The average age for first time alcohol use is 12.

If children are our future, and their future is jeopardized by threats to their health and well-being, it is clear that our future as a Nation is in trouble. This is not, in my opinion, a liberal or conservative issue, or a Democratic or a Republican issue. It is a fundamental American issue. All children deserve a healthy start because it is right. All children deserve a healthy start, because they are our future work force. How are we going to be successful in an increasingly competitive world economy, if we are not turning out healthy children who have the capacity to learn?

I spend a lot of time with our school colleagues here, and our school superintendents who say, by the time we get them, at age 6, it is already too late. They have been physically abused, or sexually abused. They have major learning disabilities. We have to intervene much sooner.

They have to be self-sufficient. They have to reach their full potential. Quite simply, investing in the health care of our children is the single best investment we can make.

I would like to, in the short time remaining, comment on a couple of points. I think what these issues need, are crusading leaders. This is going to be a crusade. There is no quick fix. We need a fundamental reordering of our priorities.

It feels to us, at times, at Children's, that we are in the Alamo. We are outnumbered. I believe that we made a fundamental mistake as a country, in the early eighties, when we decided that health care was no longer a social good—as Mr. Arce described, on the right of everyone, regardless of ability to pay—and made it an economic good. The rhetoric of the day was, let us control health care costs, you all were aware, by deregulating health care. Make it like the airlines—we know how well that has worked. Let us make it like the savings and loans—we know how well that has worked. Those were the two analogies back in the early eighties that were used to fundamentally change the health system, which we really had solved when we enacted Medicare and Medicaid. We had some problems in 1965, but we significantly closed the gap on access to care over a 15-year period between 1965 and 1980, between minorities and whites, between rich and poor.

But no one recognized the victory. We allowed this to become solely a budget issue. Of course good health care for all costs more. That is the point you both made about resources. Of course it is now a higher percentage of the gross national product. But where there were no crusading leaders, including in the health care industry. No one said, Look what we have accomplished! We have increased life expectancy, we have reduced infant mortality. We have made a lot of progress, and of course, this costs more. There was something magic about when expenditures hit 10 percent of GNP, it became solely a budget issue.

And once it became solely a budget issue, people said, well, we tried to regulate it. It didn't work. (In my opinion, it was never done on a comprehensive fashion, it was just done in pieces.) So let us make it competitive.

I am going to be very, very blunt. What you have in San Diego now is a return to a two-class system. In California, we have about 500 hospitals. In 1981, 350 to 400 of those hospital saw Medi-Cal patients. Now, about 180 see Medi-Cal patients. Children's hospitals—there are seven of us in the State—are the ultimate disproportionate share providers. We average 50 percent Medi-Cal, on which we get paid two-thirds to three-quarters of our costs. Very similar to the community clinics and the emergency rooms you have heard about, we are going to become as extinct as the condor, unless something happens.

And the county hospitals are facing many of the same dilemmas, but we happen to be focusing on the kids issues. What you are getting, when you go into a competitive model, is you are substituting many costs for expensive advertising programs. You drive in your car today, and you will hear from certain hospitals—9 or 10 ads per day about, we have a doctor for you. Some of the large HMO's that the Federal Government subsidized to not treat Medi-Cal patients. That is what you get when you make health care an economic good.

The airline will say, the route between Los Angeles and Bakersfield is not making it—cut it. Okay? If I were running Children's Hospital solely as a business, we would close our child abuse center, which is one of the three largest in the country, which costs us a half a million dollars a year. We would close the dental clinic for the handicapped, on and on and on. But where would those kids go?

So that is what I think the crusading leaders, over a decade, need to do to start to turn this around. I think Mr. Simms described it very well. We do not have one system. What we have is a system for the rich and a system for the poor. And particularly, we do not have a system for kids because they do not vote.

In closing, you used the word fraud about Medi-Cal. My phrase is, I think there is a "cruel illusion," a cruel illusion, about our Medi-Cal program. It gives people the perception that these people are "covered." If you ask the question, would you like to be a patient in California, versus some other states that have even more barriers to access and eligibility, the answer is yes.

If you ask the question, if you were a hospital or a doctor that made the commitment to try to care for these patients, we are either 47th or 48th in the country, in terms of level of reimbursement. That is how dramatically we have plunged, in terms of reimbursement, since 1981. And that is the legacy of competition in health care. And I think that is fundamentally going to have to be addressed. And I think it is going to require leadership for both sides of the aisle, to recognize that we are going to have—we are creating an entire generation of unhealthy, illiterate kids, who cannot compete in the international work force.

Thank you for letting me go ahead of the rest of the group, and sharing these comments.

[The prepared statement of Mr. Sadler may be found at end of hearing.]

Mrs. Boxer. Thank you very much. I would just say, you have been very eloquent, very moving. I think some of your quotes will remain with me for a long time. The 1980's was the decade that

America forgot its children. What an incredible comment and commentary on our decade of greed. Decade of neglect. I agree with you.

We are paying the bills. And the bills are going to be far higher than we ever thought. Not just in terms of health care, but in terms of the issue you cited, which is the ability to compete now. The cold war is over—we are in an economic war with the Asian nations, with the European nations. And we are not going to have the work force. In the year 2005, only 15 percent of the work force, eligible work force, will be white male. The rest will be of female gender and minority. And we are losing these kids. And as you pointed out, you are losing them in San Diego.

Babies are having babies, teenage suicides, abused children—4,000 children will be born this year in San Diego, drug-addicted, alcohol-addicted.

One of the things that I am toying with—and I have not put it together yet, but it is in my mind—and I just want you all to think about it, and maybe you can help me formulate it. When you buy a new car, which we do in our house about every 9 years or so, you get a book. It is a checkup book. After so many miles you have to do such and such, and you bring the coupon in, and the garage guy checks it off. I think every baby that is born should have a well baby book. And should have the basic needs of that child set forth in the book. The parent needs to make sure that those things are done. And we have to stand behind that. Whether it is with a national health insurance program, a program that works.

And so, I would like you to think about it, because it obviously is going to take a great deal of work to design such a program. But it offers something simple, and a recognition that our babies need attention to all kinds of things. I mean, I am a mother of two who are now in their twenties. From the minute that I knew I was pregnant, my whole life changed. And when those babies were born, and it just seemed to me that everyone knew that. But people do not all know that. Especially, if a woman gets pregnant at 16, and just does not know.

So we need to step in, on the side of an innocent child. Sometimes that 16 year old is an innocent child, but it may be too late to do certain things for that child. Although, we have found, as we look, for example, at the Head Start program, that the beauty of those programs for the babies, is that the mothers and the fathers get involved, and it changes their lives. So the child can be seen as a vehicle to really educate the whole family.

And we should look at it as an exciting opportunity, if we can, rather than a failure. If we look at it as an opportunity, and we approach it that way, and we put the resources behind it. And I agree with you. Somehow, when health care became x percent of GNP, it was time to panic. Excuse me—is that not a sign of a society that really cares about its people.

Nobody looks at the military budget in that way, and says, oh, my God, the military budget is more than 5 percent of GNP. It is time to cut it. I never saw that. You do what you need to do to protect the country.

Well, we need to do what we need to do to protect our children, who, as you point out, Mr. Sadler, are the hope and the dreams of

our country. So I just want to let you go to your airplane. But I want to tell you that you—well, you moved me to tears, first of all, with some of the things that you said, and you only make me feel all the more determined to take this message back. So go in good health, and have a good trip.

Mr. SADLER. Thank you.

Mrs. BOXER. Thank you very much.

Mr. SADLER. I hope you will share that cruel illusion with others.

Mrs. BOXER. I think it is terrific. It is very good. And your testimony will be in the record for all to see, and I thank you very much.

Mr. SADLER. We have a very close working relationship between the Children's Hospital and the schools here, because we believe we have to work together.

Mrs. BOXER. Excellent, excellent. Thank you very much. Ms. Firth, we get to you.

STATEMENT OF LISA FIRTH, REGIONAL COORDINATOR, SAN DIEGO AND IMPERIAL COUNTIES REGIONAL PERINATAL SYSTEM

Ms. FIRTH. Good morning, Congresswoman Boxer. Thank you for this opportunity to present testimony on access to care for childbearing women, and their infants. I am regional coordinator for San Diego and Imperial Counties' Regional Perinatal System, which is one of the network of State funded programs. Our aim is to promote the health of women and infants, through the provision of high quality, accessible, comprehensive, and integrated perinatal health care services.

Prior to coming the United States, I was an obstetrician, working in the British National Health Service. As Mr. Sadler has said, to invest in newborn infants is surely to invest in our future. And during times of fiscal restraint, it is very important that we invest wisely. I feel that Government can play important roles in two critical areas in doing this.

First, in access to care, and second, in the integration of the perinatal health care services. Prenatal care has, in many studies, been proven to be cost effective. It varies a little, depending on which studies you read. But certainly, an investment of the dollar in prenatal care gives a return, just in short term care for the infant, of $3 to $4. When you consider long term costs of health care for the child, or even more so for the societal costs of children who may never realize their potential as adults, this investment seems to be a very good deal indeed.

Why do women not get prenatal care? When I worked in the British Health Care system, I only recall ever seeing two women who failed to receive prenatal care. And they were women who had concealed their pregnancies for various reasons. But everyone who came forward for care, was identified as being pregnant, was able to receive services appropriate to their level of need.

I think that we can look at this from two perspectives. From the availability of providers, to give care to these women, and from the perspective of the willingness of women to seek care. I think the provider availability issue is certainly the most critical. Because, generally, women know that they need care, and they are anxious

to have the care that they need for themselves and their infants. But the problem is that they can very often not find affordable providers.

Here in San Diego, we do, indeed, have a crisis. I collect no care statistics from our hospitals around the county, and not including the closed systems, such as the Navy and Kaiser, which take care of their enrolled patients, we have about 10 percent now, of women in this county, who receive either no care, or grossly inadequate care when they are pregnant. That is about 4,000 infants born in San Diego County each year, whose mothers did not receive the most basic of prenatal care.

We have made some progress in this issue. We have been working hard, and with Government help, we have had some gains. And I think these figures would be worse if that were not the case. But we still have a lot to do.

There are several things that I think can be done to enhance the availability of providers. Firstly, the use of midwives and nurse practitioners. This has been shown to be cost effective in extending physician services. And at the moment we only two hospitals in San Diego County that use certified nurse midwives for deliveries. They do need encouragement—hospitals do need encouragement, and physicians need encouragement, to back up services that are offered by nurse midwives. They have to work in partnership with hospitals and physicians.

And with this in mind, we need to develop new partnerships. We have a strong network of San Diego Community Clinics, as Mr. Arce said earlier this morning. And they are able and willing to provide prenatal care to these women. But very often, they are unable to find the physician and hospital back up to provide delivery services for the patients that they could take care of, throughout the pregnancy.

Also, as Mr. Simms said earlier, we must recruit and retain providers. And the key to this is to make sure that payments keep pace with costs. At the moment in San Diego, one of our model programs based at the University Hospital, is facing closure because it simply cannot meet its bottom line. It would run in the red at $200,000 to $500,00, even with the most careful management. So we see that Medi-Cal is not providing adequate compensation for care.

Not only for physician and prenatal care, but hospital reimbursement is important. And many people have been able to speak eloquently to this, this morning. Most of our hospitals in San Diego County who do delivery services, do have a Medi-Cal contract, and take care of Medi-Cal patients. But those of us who have been working on this problem, are afraid that we will lose some of those hospitals as their reimbursement falls further behind the cost.

And of course, we need to keep the Medi-Cal process simple and avoid the delays that so often discourage providers from participating. This year, in the California State Legislature, a wonderful bill was introduced, and passed both houses, which would have provided a continuous——

Mrs. BOXER. Can you speak a little louder?

Ms. FIRTH. Yes, I certainly will. We had a bill in the legislature, the State legislature, this last session, which would have provided for continuous eligibility for pregnancy. And that was vetoed by

the Governor. And I feel that the Federal option of continuous eligibility for pregnancy should not just be an option, but a mandate to states to provide that. This was supported by the Health Service Administration of the State, and by many of us who work in health care.

In San Diego, we are a border community, and we are in dire need of qualified, bilingual staff to care for these patients. Either to train minorities to provide care to their communities, or to train existing health care providers to be bilingual and bicultural.

And finally, since we do not always have the services in the areas where we need them, to provide transportation, and child care, and other support services, so that women can reach the providers that they need.

The second aspect is patient education. This will be more appropriate when we have sufficient providers to take care of the patients that we bring into the system through education. We have made some progress in this also. We have a new hotline in San Diego, which women can call—a toll free number—to help them find prenatal care. And this has been very successful.

We also have a prenatal care guidance program, which is based in the county, funded through tobacco tax moneys, to do outreach to pregnant women, and to keep them in care, and support them with the services they need to stay in care during their pregnancies.

And we also have an information campaign that has been started, funded by the March of Dimes, to let women know that they do need to get into early care, and to show them how to apply to Medi-Cal, and what to expect when they go to the Medi-Cal office.

What do we need to improve matters? I think the two things that we need to overcome most are fear and ignorance, in the women we serve. So consequently, we need to expand outreach, especially to our border population. Very often, fear of deportation prevents women from coming forward, for the care that they need. But we are going to see these women anyway in our emergency rooms, and often with more complications than they would have had if they had sought care earlier.

We also need to improve services for our substance using pregnant women and their infants. Senator Killea spoke this morning about the pregnant inmates program. That is part of a larger pilot program here in San Diego, called Options for Recovery, a multiagency program which has brought numerous providers together to provide very successful model of family centered care for women who are substance using. I was involved in the early planning of this problem, and chastened to hear one of the senior social workers in the county say, well, this is going to be a wonderful program, but it can only take care of the women we know about now. There will not be enough slots to identify any more of the women who may be out there, and needing services.

Also, we need accessible, affordable family planning services. Let us not burden our citizens, our women, and our health care services with unplanned and unwanted pregnancies.

Okay, the second issue is——

Mrs. BOXER. I am going to ask you to kind of wrap it up, because I am afraid we are going to run out of time.

Ms. FIRTH. Yes, sure. I would like you to read my written testimony on integration of services.

Mrs. BOXER. Yes, we will. And if you wish to summarize your other points, go right ahead. You do not have to read every word because your written testimony will go in the hearing record.

Ms. FIRTH. Okay. I think that regional coordination of perinatal services is needed to get women into the correct level of care, so that they do not have to use resources in our tertiary care centers, that could be used for the few that need them.

There needs to be bridging of professional and institutional barriers, so that we can all work together on the problem. And this needs strong government leadership, and stable funding, for programs that work.

So in summary, in these times of fiscal restraint, and escalation in health care costs, it is essential that we invest wisely in the future of our youngest citizens. Health care providers are generally willing to work together to solve problems that we face in the provision of services. But we rely on government leadership to assist with coordination, and to provide adequate, stable funding for programs that work.

[The prepared statement of Ms. Firth may be found at end of hearing.]

Mrs. BOXER. Thank you. I want to tell you, I have a copy of the Medi-Cal form. I am going to give it to the press, because really I do not see how any one of us in this room could do this without an extraordinary amount of help. Then again, when you get through it, on the last page, it says—I must read this. It is 11 pages, and tiny, tiny print. And on the last page it says—"I realize that if I deliberately made any false statements or withheld information, I or the person on whose behalf I am acting, may lose Medi-Cal eligibility, and I could be prosecuted for fraud."

So it is just a frightening prospect, because when you look at the details that they ask for, I think any honest person could say, oh, my God, I forgot that. And then, have to prove that they forgot—it was not intentional. It is something I would like the press to look at.

And I thank you very much, Ms. Firth. And ask Ms. Beck to proceed. And she is with us from the San Diego City Schools, right on the ground of some of these problems.

We welcome you.

STATEMENT OF JUDY BECK, R.N., NURSING SUPERVISOR, SAN DIEGO CITY SCHOOLS

Ms. BECK. Thank you very much for the opportunity to testify. I am speaking as a nurse practitioner, employed by a large urban school district. San Diego Unified School District is the eighth largest school district in the country. It serves 120,000 some students. So I think we could consider my experience in terms of providing health care to children enrolled in schools as being somewhat typical of other school districts throughout the country.

I am also the project director of a State-funded case management program for pregnant and parenting adolescents, including a program that provides special services for pregnant teens who are sub-

stance abusing. And that is an area that I can discuss at some length if there should be interest.

The health needs of students enrolled in public schools today are affected by a number of different factors. We can no longer consider a school age child to be age 5 to 18. Because of the impact of the handicapped legislation, we are now seeing in the schools, and we are serving in schools, very young children—infancy, toddlers and up to age 22. Those handicapped children have very substantial health needs. This has a considerable impact on education and on the staff—the health care staff—that provides those services.

The children that reside in the convalescent home that Blair Sadler mentioned that is run by Children's Hospital—all of those students are eligible to attend our schools and do so, regardless of the profound nature of their handicap. These kinds of situations provide considerable stress for education systems, and I think, is perhaps not widely that this impact is considerable.

We are impacted by the decrease in the number of intact family environments, and that has placed increasing responsibilities on school personnel, to make decisions and solve health and social problems for children. And often, this is done in a crisis situation, rather than as a problem solving, with long-term solutions. These are the children that end up in the emergency rooms, or crisis-oriented care with no follow through. And we are seeing that from our perspective, as very poor health care. Aside from any of the fiscal aspects of it, it is the kind of care that has no continuity and is, in fact, very dangerous.

There are large numbers of families in our community who do not have medical insurance, and you have already heard statistics on that. And those who are not eligible for Medi-Cal coverage, because we, in fact, in the schools, see large numbers of families who are undocumented citizens in this country, and as such, are not eligible, and are not comfortable applying for any kind of public aid.

These families have no resources for health care. These children are attending schools. Many of them have serious health problems, both chronic and acute, and we have no mechanism, no referral source, for those children. This poses a tremendous burden for us, for the health care professionals in school, and those problems are virtually unsolvable.

Educators, I think, are well aware of the need for children to be well rested, well nourished and healthy, in order to learn in school. But speaking as a person employed by public education, I feel that I must speak out and say that we do not have the resources to solve the kinds of health problems that we see on a daily basis.

Traditionally, school health services personnel, namely, school nurses—and, on my staff, I have 120 school nurses who are very well qualified. Forty-seven of those are nurse practitioners. We are screening children for health problems. We have enormously long lists of children who have unmet health needs, and no source of health care. In years past, it was easier to find sources of care. There were free clinics. There is no free care anymore, and these families are without resources and without finances. Their priority is food on the table, and it is not the draining ear infection, it is not the abscessed tooth. They cannot afford to handle those problems.

My recommendation is, and speaking as a school person, I address this in my testimony, written testimony, the solution for this, I feel, has to be an interagency approach. Children are in school every day. We see them. These are the children that are never seen by the private medical community. They are never seen by the community clinics. They are never seen because they do not, in fact, get there. We see them everyday in school. We cannot meed their needs.

However, I would speak as an educator, and I am sure that educators would join with me in saying that they would be more than willing to work together with other agencies—social services, public health, and other kinds of medical care providers, in order to provide that care at a school site, where the children are available, and where they could receive those services.

Mr. Sadler mentioned a close working relationship with Children's Hospital and the schools. We anticipate at one of our sites that Children's Hospital will be, in fact, providing some primary care services on site for some of our high school students.

We have another school setting that is working on a new concept of a multiagency approach, where the department of social services, the department of public health, the school system, and several other agencies are working together to combine our staff personnel into a service center that would meet the needs of the population in the given school community.

That, I think, has to be looked at as a way of providing services for children. There are too many children who are falling through the gaps, are not eligible for care in any of our organized systems, and yet, with a very small amount of augmentation, those services could be provided at or in after-school programs for health care. So I would like to suggest that that be something that be considered in the future.

Our adolescent pregnancy program—you have heard, I think, at some length about the problems of pregnancy and access to care for prenatal care. Our Adolescent Family Life program provides case management approach, and that, also, is a multiagency approach to provide care for young pregnant teens, utilizing existing services in the community. So it is a cost-effective approach, in that trained case workers can link up students or non-students, as the case may be—pregnant teens who are not knowledgeable in use of the health care system, and can, in fact, make better, more cost effective use of those services for students.

So that program, without taking up a great deal of your time, is now in its fourth year, and is providing some very successful services for students, both in the nature of health care, but also in retrieving those students back into the school system.

[The prepared statement of Ms. Beck may be found at end of hearing.]

Mrs. Boxer. Can you teach children about—young girls and young men—about contraception in the schools here?

Ms. Beck. To a limited degree, yes, we can. And that is done, always, with parental permission.

Mrs. Boxer. Right.

Ms. Beck. And so long as that is up front, and we have a system within our school system of doing that on an annual basis. Parents

have access to that information ahead of time. Parents have the right to withhold, or withdraw their student from that particular session, but that information is available in the classroom. It is also available by nurses on an individual counseling basis.

Mrs. BOXER. Do most of the parents approve of it?

Ms. BECK. Most of the parents do. A very, very small percentage withhold that permission.

Mrs. BOXER. Well, thank you very, very much for your time and your testimony. Dr. Bowen, welcome.

STATEMENT OF DR. NANCY L. BOWEN, CHIEF, MATERNAL AND CHILD HEALTH, SAN DIEGO COUNTY

Dr. BOWEN. Good morning. This morning I am going to talk a little bit about the health problems of children, and something that you have already heard, some of the broad issues, so I will make that very brief. I will also talk about some of their unmet health needs and look at a few models on how to approach these problems.

Most of the children in the United States are healthy, but we are not doing as well as we could. And addressing these problems in early childhood can benefit a child through an entire lifetime. The burdens of lack of health care access, illness, disability and death are not borne evenly.

Some of the subpopulations that bear these problems, in a disproportionate share, are minority children, particularly black children; low-income children; homeless; foster care children; infants are part of the subpopulations.

We have talked today, already, about the insurance problems. Overall, children's health care needs can be most effectively addressed in the context of a comprehensive national strategy, as Blair Sadler hopes we are moving to.

They need to take into consideration the changes within the family that have an effect on the way children get access to care, and their health status. As Ms. Beck was saying, where are the children who are in schools, that no longer have families with the typical head of household. They are usually largely employed, and are not going to be able to take off work to take her to a doctor's appointment. That is just not a reality, because of the large percentage of moms that are working. The percentage that the mom is the only parent in the family, and we have talked quite a bit about the fact that so many children being in poverty, and without health insurance. All these factors have to be addressed, looking at a battering arm of our health centers for our children.

Some of those specific areas that need to be looked at, you talked already about easily accessible prenatal care services, including poor teenagers; increasing access to well child visits. I will just talk a little bit about the important components of that.

The promotion of good health habits, through the schools, churches, social clubs, medical providers and the media. So many of the problems that children have during childhood, such as injury prevention, requires some health education, but also our long-term. You need to establish these good health habits in childhood, and we do not right now have any coordinated function to do this kind of education of children.

Besides injury prevention, physical fitness, these are important parts of the physical state of physical fitness of children in our country. Good nutrition needs to be emphasized. Healthy ways to reduce stress. That thing that I always try to look at prevention of drug and alcohol abuse. And you have to take that one step back. Why are people choosing that as a way to alleviate their stress? They do not have a good informational model, easily accessible recreation, so that they can choose other ways of dealing with stress, besides the smoking, drinking, drug abuse sorts of behavior.

And what we have already talked some about, we, as a country, in order to solve the problems of teenage pregnancies—this requires open discussion; training of health professionals because kids ask those hard questions; more effective health education—maybe more than just an annual class—and then, increased access to family planning.

We need to have an adequate system so that when child abuse/neglect families are identified, we do not go out there and decide, well, 15 percent of them are so bad that we are going to get them into our legal system and take them to court. We need to have a system to support this, such as home health visitors, as our public health nurses do, where we can go out and do activities that can help prevent further abuse or neglect, or be able to do a little more investigation, and perhaps get some of those kids into the system that resources can provide.

The home health visitors assess the home environment, and most importantly, link up those parents to programs that can either help support or teach them parenting skills, and teach them what to expect of their children. A lot of people just do not have this basic education on how to be a good parent.

Also, an area that we are lacking—that is not a frivolous service—is that in the area of dental health. That always seems to be an optional sort of thing. Besides dental care coverage, access to fluoride, dental sealants, classes on dental hygiene.

I have not listed here, but Blair Sadler mentioned earlier also about access to mental health care services. That also seems to be put in that class that some people think frivolous.

And then, aggressive immunization programs, that reach kids at an early stage. One of those children that Blair Sadler alluded to, that died in Children's Hospital of measles complication, cost $800,000 to our health services, and the child died. Compare it to the cost of just the common immunizations that would have helped. The child was kept in ICU for about 4 to 5 months.

Mrs. BOXER. $800,000?

Dr. BOWEN. There was a bill of $800,000 to be picked up between the county and the State.

Then, we need a system that provides formalized, comprehensive health assessment, referral and followup for foster children. They are, in so many aspects, certainly get lost as far as their health care goes, in the system. And yet they definitely are our responsibility directly.

And then, the programs for homeless children. Those, again, some of the saddest population you can imagine. And the health care services to those children are again dismal.

I have some background health statistics on children. A lot of these you have already discussed about the lack of health insurance—but that problem is worsening in the 1980's. But then, I also have a table here that looks at San Diego County. What does a family look like with a female as head of household, and she has preschool children in her home. The amount of income that that family sees per year is markedly less than other kinds of family structures.

And you can see what is happening in San Diego County with our infant mortality rates, as has been discussed already. A problem that is alarming, you can see here our general fertility rates are particularly increasing in mothers under the age of 15. Now, that is, that is alarming. Plus, the gradual increase in other teenage pregnancies.

A table that I took out of this study that compared the United States to 37 other industrialized countries, trying to look at our teenage pregnancy rates, and to look at all the social factors, health factors—what are the things that are associated with a high teenage pregnancy rate? And they found that in those countries where there is a lower teenage pregnancy rate, there is a greater availability of contraceptive services and sex education. It is pretty simple. I know it is very political.

Mrs. BOXER. Not to me.

Dr. BOWEN. The national defense is that this is happening, and we have to do what it takes to address it.

And then, finally, I just have a graph that shows dramatically our deterioration of access to prenatal care in this county. And particularly glaring is the Surgeon General's goal for the year 2000, as it was in 1990—is that 90 percent of all women start prenatal care in the first trimester. That is when a lot of the major organ development is happening. That is when it is going to pay to change their behavior. So if it is not early, it is much less valuable.

And you can see that we, over the 1980's, went out with almost 80 percent starting in the first trimester, to about 80 percent, or 70 percent.

And then, finally, this has been touched upon already, the very significant problem of perinatal substance abuse. This is a new area that there is still a lot of scientific research that we need to do, as far as what are effective programs to intervene. If there are going to be successful models demonstrated, that they are going to be expensive.

[The prepared statement of Dr. Bowen may be found at end of hearing.]

Mrs. BOXER. Thank you. Yes, I just want to say, I hope you will not believe that family planning is political. Because, I think it is a health issue. And we cannot allow people to make it political. No more than we can allow people to make AIDS a political issue. These are health issues. So please, be strong in your conviction that these are health issues. And do not be fearful, because I think that people who feel they are political and try to make them into political footballs should be called on it.

And I want to thank you for your excellent testimony. Dr. Willis?

STATEMENT OF WINNIE WILLIS, ASSOCIATE PROFESSOR, SAN DIEGO STATE UNIVERSITY

Ms. WILLIS. Thank you. I am going to present testimony on the issue of African American infant mortality. The problem of infant mortality is directly related to the incidence of low birth weight. Therefore, all strategies for prevention of infant mortality for African Americans must address the prevention of low birth weight. Data from the National Center for Health Statistics for the years 1983 and 1984 show that the low birth weight rate for African Americans was 12.7 percent as compared to 5.6 percent for whites, a twofold difference; and that the cause specific infant mortality rate attributable to low birth weight was 224 per 100,000 live births for African Americans as compared to 62 per 100,000 for whites, nearly a fourfold difference.

African-American infant mortality is twice that of whites. It is 18.7 versus 9.1, per 1,000 live births. African American neonatal mortality is twice that for whites—it is 12.2 versus 6.0, per 1,000 live births. African American post-neonatal mortality is 6.5 versus 3.2, per 1,000 live births for whites.

M. Harvey Brenner, in an article published in 1977, and probably reiterated many times since, proposed a theory about factors influencing health. And this theory, for me, serves as a framework, as I consider causality, as well as I consider approaches to solving the long-term problem of the disparity of the black and the white races on the issue of infant mortality.

This theory states that there is a relationship between national economic policy and health status. And that theory further states that, apart from the economic interdependency of family members, there is a diffusion of psychological stress, which is generated by economic trauma. I would go so far as to say there is a diffusion of total stress, not just psychological, as indicated by some of the data given by Mr. Sadler, relative to the issues of intentional injury in families. And it appears that economic trauma is—or economic problems is a critical factor, when you begin to discuss dissolution and breakup of families.

Dr. Stennes mentioned some overriding broad issues that have not yet been addressed by the Nation. And I think most of what I am going to say from this point is addressed to very overriding issues. Not the specifics of health for African American infants, because a lot of those details have already been given.

But let me go back to the theory proposed by Harvey Brenner. The relationship between economic policy and health status is illustrated in a 1984 report of the Urban Institute, which states that between 1980 and 1984, blacks in all income classes suffered declines in their income and standards of living. The average middle-class black family has a lower standard of living in the 1980's, just as the average poor black family.

There has been a widening income inequity between blacks and whites since 1980. The national economic policies of that administration—and many of them continue—included cuts in programs such as AFDC, food stamps, subsidized housing, job training, all of which have a very significant proportion of African Americans involved in the programs, and all of which have a direct impact on

the well-being of African American families, especially pregnant women and infants.

During this period, it was observed that the infant mortality gap, which has been there from the beginning of the keeping of vital statistics, was actually widening—during the 1980's, it actually widened.

Let me now address the effect of stress generated by economic trauma. This effect is described not only as that related to unemployment, but also related to the fear of unemployment, and to underemployment. A particular characteristic of the 1980 years was the continuation of disproportionate unemployment of African Americans, from 14 percent in 1980 to 16 percent in 1984. While white unemployment declined—only slightly—but declined.

The number of African Americans in the category of long-term unemployed—that is people out of work at least half a year, who are still looking—increased 72 percent in the 1980's, as compared to 1.5 percent for whites. Resulting family stress can be linked to, during pregnancy, for the pregnant women, can be linked to alterations in eating patterns and self-care patterns. And these are patterns which are critical to the progress of pregnancy. In addition, there is a dissipation of energy, and this energy, which would better be spent in the carrying through of a good pregnancy, is dissipated in simply trying to cope for certain of these families.

Research is currently being done which suggests, also, that stress may be implicated in premature births, hence, low birth weight. In this country, as has been so ably presented already, a lack of employment or underemployment means no health insurance, without which, access to good prenatal care is severely limited. And in spite of the access that Medicaid has afforded some, there are multiple problems with eligibility and provider satisfaction.

Due to their poor economic status, many African Americans live in areas where there is poor housing, where there is crime, where there is lack of access to usual public services, like transportation. But these underlying issues are often ignored, or overlooked, because race is given as the explanation for adverse health outcomes. But the actual experience of some of the states and local areas has been that women of similar economic class, regardless of race, have similar pregnancy outcomes.

Therefore, effective strategies to affect infant mortality among African Americans, must include policies and programs which support the life of the family. These are policies supportive of full employment, of equity in wages, and policies which support the same empowerment and access for ethnic minority communities that is available for the largest society.

I would like to say, in conclusion, that an example of the experience of women in similar economic class, in terms of pregnancy outcomes, was illustrated by myself in this past year. I had a pregnancy in which my daughter was born at 2 pounds, 5 ounces. And because both my husband and I were insured, and because we are both employed—we are the lucky ones—my daughter went through a 3-month neonatal intensive care unit experience, but is currently 17 pounds and doing all of the things that she is supposed to do in terms of development, with no obvious delays at this point.

So it is, to me, an example of access to care, regardless of my race. And I think it is critical, when we are talking about national policy that, if there are statistics that can be achieved by any segment of the population, good statistics regarding infant mortality, that same statistic can be achieved by all, with equal access and equal empowerment and ability to get services.

[The prepared statement of Ms. Willis may be found at end of hearing.]

Mrs. BOXER. Thank you very much, Dr. Willis. And I can tell you, both my babies were premature, also. Just these little wee things. And they turned out to be terrific, and they are in their twenties. So I think that those little ones sometimes exceed all expectations.

I want to thank all of you for participating in this, and I think we have got to make the nineties the decade of the child, or beyond that, we are just not going to be able to match other countries. We are just falling too far behind. I thank you for helping us and giving us your wisdom. Thank you very much.

We will proceed to our final panel, Joe Stern, senior advocate and Susan Hoekenga, executive director, ElderHelp of San Diego. We welcome you. I want to thank you for your patience. It has been a long morning. Mr. Stern, we are very happy to have you. Would you like to open up?

STATEMENT OF JOE STERN, SENIOR ADVOCATE

Mr. STERN. Thank you. It is a pleasure to see you again. I know you are busy with all the important things like Iran and Iraq, and going over the budget, especially in this last week, when it concerned our services for health care.

I had to notice that the first set of people to testify were men, and after that came women, and you finally come down to the public. I do not think that that was done on purpose, but I think it was sort of a subconscious business that none of these women who, with the training they do have, maybe that men are in higher positions in our society, and I feel that it is something we have to be conscious of.

Mrs. BOXER. Well, Mr. Stern, let me call to your attention that Senator Killea was in the first panel, that I am sitting up here, and in addition, the way we made our panel, we wanted to have the first, elected officials, and then the second, an overview.

And I guess you are right in the sense that some of the women are not in those higher positions to give the overview. Then, children and then the elderly.

So it was not men, women at all. It was by topic. But you go right ahead. I appreciate your sensitivity to the feminist cause. And I certainly share it.

Mr. STERN. I want to call to your attention another fact, that I did not speak intentionally here, and that was the overwhelming majority of the problems concerning health care, I think we do need. This is true whether we are dealing with seniors, or the general population, or teenage girls who have the problem of pregnancy. Or pregnant women who have responsibility of themselves,

their own care, their child's care. Or mothers, after the child is born.

Mrs. BOXER. That is right.

Mr. STERN. So at least 80 percent of the health care is concerned with problems affecting women. I did not really understand what my obligations were. So I will testify first in my official capacity, as a member of California Health Access, San Diego Health Access. Our one purpose is to provide health access to everybody in the State of California, and if possible, in other states.

We have all heard many horror stories which I personally hear from the county, extreme instances. Because you can find thousands of theories buried in the hundreds of theories which have already been developed on this subject. All these things have left from those hearings is about paper, and I hope that this hearing will become more productive. And I tend to believe it will, because health care is presently becoming most important.

The superiority of national health care for has been proven in many countries over many years. Those countries that had national health care has been reverted to keep services supplied. This should tell us something. This should tell us something. We claim to have the best health care in the world. The best is where people have full access to this security of care. I think this is the point of the day. Our regular life expectancy and infant mortality ranks far below countries with national plans. And countries that spend far less of their GNP, per person, on health care. It is obvious that we are not getting our money's worth. It is also obvious that many Americans are suffering physical and financial trauma, unnecessarily.

San Diego Health Access supports a national plan, which is comprehensive and affordable. It should cover long-term care and prescription drugs. We must have stringent cost controls. Now, we come to the important part.

If you believe that only a single care plan can meet these requirements. Such a plan would eliminate private insurance, and reduce waste. Under a single care plan, all billing would go into a single computer. Waste and fraud would then show up, and could be corrected. Canada has controlled waste in this manner for many years. Their health cost is $25,400—and they cover everyone in the country. Their coverage includes long-term care, prescription drugs, and most importantly, preventative care, which I will get to later. Their emphasis on primary care helps prevent more serious problems. At first the citizens were unhappy, but now they seem quite content.

Mrs. BOXER. Go ahead, I am listening.

Mr. STERN. That is okay.

Mrs. BOXER. No, I am. Go ahead.

Mr. STERN. Now, the only ones who are now complaining about the Canadian plan are the AMA and some American doctors. Under pending legislation, San Diego Health Access supports 5300 by Stark, and California Senate bill 2868 by Finsten. Both of these are similar care plans, which include long-term care. But we cannot afford this agreement among all the participants. Insurers will not agree to eliminate themselves, and doctors will not agree to limiting their bright and quotation marks, which charge more

than the traffic will bear. Governments will have to enforce a plan for all parties concerned.

At present, there is a widespread deception that the Congress has the same kind of cozy relationship with the health industry that they seem to have with the S&Ls. It does not matter that much whether this is true. The perception is ruining the confidence of Americans in their government. It is also ruining the moral fiber of this country.

It took a President Roosevelt to finally get Social Security for the country. It took a people of the civil rights movement down South, and Lyndon Johnson to finally get us Medicare. Both came through to huge protests. Will it take one more deserving Congressman to finally give us a national health care plan? Will it take another national emergency?

The present anti-incumbent movement is a sign of widespread discontent with the Congress. There is a people that Congress does not care about. Many people are saying, what is the use of voting? One issue for which this contender is a problem is a long delay over acting health care. We have been having hearings for 15 years or more. The populace believes that this is due to collusion and to legislators and to the Congress. Make no mistake. Supporters of national health care will suffer, along with their opponents, and those people in Congress. The public will not discriminate. They all will be painted with the same brush. To prevent this, Congress should enact a national health care plan which is affordable, comprehensive, and which would include long-term care, prescription drugs, as soon as possible, and let the chips fall where they may.

And now, if you please, I will speak as a private citizen, as an advocate for 20 years, and as a person who has long pent-up frustrations over the question. I feel that we have a typical system in which the marketplace decides what shall be paid. Under our present setup, in which many people having insurance, the doctors and hospitals compete for those people to take who has the highest insurance. They treat people by providing us with the most luxurious possible consumers. In automobiles, it would be like designing a system where only Mercedes-Benz's were available to people.

This is a system which we cannot afford, and which we cannot tolerate. In finalities in California Senior Legislature, of which I am a member, I am an elected senator, for 7 years, we have adopted the same No. 1 priority, a comprehensive, affordable health care plan, for all Californians, which would include long-term care and prescription drugs. The same No. 1 priority for this hearing. For another priority, we suggested that they provide mobile medical vans to care for people who are far from existing medical facilities. The vans would treat minor problems, and refer more serious problems to other facilities. It is absolutely ridiculous that we have developed a system where people have to go to emergency centers where it can cost from $100 to $200 for the most simple health care treatment. It does not make sense.

This happens because the medical profession controls the health care system. We have a misunderstanding somewhere in this country. The terms are confusing. Health care is provided by medical care providers. I think we should develop a hierarchy of priorities,

to prioritize our health care needs, to insure that the most necessary needs are met before others are met.

Before I go into that, I might say that I disagree violently with the debate over the fact that we need more money. We do not need more money. We presently are paying more money for health care for any country in the whole world. We are not getting our money's worth. We are paying 11.5 percent of our gross national product, and in a couple of years, it will go up to 15 percent, because the insurance companies and other health providers have not demanded we have some kind of decent cost controls in our system.

We are providing Mercedes-Benz's to people, when all they need is transportation. We can provide—if we took even 10 percent of our gross national product, and used it for health care for all the people, we could have health care for everybody, that would be more than adequate. No question about it. And the other 1½ percent, let them take private insurance for their special needs, and we will do with the general health care, like they have in Canada, in Sweden, in Norway, in Germany, Great Britain, and in every other civilized country in the world.

To go on, let me say that what has happened now, is that we are being with each tree as if somebody were in a forest. The fact that we do not have mental health care represented here, the fact that we do not have the handicapped here, or the people who are born with physical defects. I do not blame the committee for not having them here, but the fact that we deal with each one of them separately, and we have an Alzheimer's committee, and a committee for this disease and that disease, means that we are pitted against each other, for a section of the pie.

And when one becomes more powerful, because they make demands to you, and you give a little more of the pie, the rest of us are going to suffer. Because, even within the budget that you adopted, Mr. Bush has the right to allocate funds from one big area to another. And that was not known to us before the budget was passed. Within the area of social services, he has the right to take from social services, alone, if we have a crisis.

What I am saying is that, willingly or not, we our subjected to divided rule. We are subject to a vicious system, which pits us against each other. And we need to unite, and we need to present a united front of consumers against those people who are ripping off the system, and who are getting more than their share. If people in the Armed Forces can be forced to serve at a standard price, then let us ask ourselves, is this not also a civic requirement, and should doctors not also have to serve at a set price.

I want to call to your attention that when our country framed the Constitution and wrote the preamble, they put within it one section that said, the purpose of those is to promote the general welfare. If they eliminated every other word in the preamble, this would be sufficient. And every single penny that we pay in taxes is for only one purpose. And that is to promote the general welfare.

And I ask you to ask yourselves, and to ask your fellow Congressmen, where do we rate among the general welfare? Are we less important——

Mrs. BOXER. Mr. Stern, I think we are getting off the point, in this sense only. I am here because I care about this issue.

Mr. STERN. Let me turn my hearing aid on.

Mrs. BOXER. Okay, I said I am here because I share your concerns. I do not need to be lectured to, I really do not. What I would like to do, is thank you for your testimony. I would like to call on Ms. Hoekenga, then I will get back to you with some questions, if you could just wait.

Mr. STERN. I thank you for your time.

Mrs. BOXER. Okay. Well, we thank you.

Mr. STERN. I appreciate the opportunity to testify, and you can excuse my frustration.

Mrs. BOXER. I do. I feel it as well.

Mr. STERN. We are terribly frustrated.

Mrs. BOXER. Right; I know.

Mr. STERN. Every poll shows that the people want national health care. And I know that you are one of our supporters, and I have to let out on you——

Mrs. BOXER. No; I totally agree. I do not have a problem. I just want you to understand that the purpose of this hearing is to bring back even more of the frustration, the problems, and you have helped me do that. I want to thank you for joining us.

I want to assure you of one thing. Under the summit package, and my staff has just affirmed this, the President cannot take from one program, and use it in another program. He cannot do that.

Mr. STERN. Oh, he can take, he can take from human services, alone, though.

Mrs. BOXER. No, he cannot. The budget—but that was a mistake. There is nothing in the budget that allows him to make those moves. He would have to come to Congress and recommend a reprogramming. And we are not going to have that. We are not going to allow that. I do not want you to worry about that.

Mr. STERN. The President—what is that, the budget has been divided into three sections. And when we examine those, the President can adjust that sector alone——

Mrs. BOXER. Oh, he means the sequestration. Yes, but you have to know in the social services side and the domestic side, we have cushioned the amount of dollars, and we came away with a decent deal.

You are right. If any of the areas go over the ceilings, yes, then there will be, we will have to cut them back. You are right on that.

But I thank you for coming. I appreciate it. I understand you frustration. As a matter of fact, I share it. Mr. Stark's bill is an excellent start, because it allows us to expand Medicare, to include everyone in the country, to make it one system.

Mr. STERN. I just want to say that until we take the planning of health care and the allocation of services out of the hands of the millions of providers, we will not begin to solve this problem. And we cannot put everybody in a room until they come to a decision. That is like putting the lion in a room with the lamb, and locking the door, and saying, come out with a decision.

Mrs. BOXER. I understand. I do, and I appreciate it. Thank you. Ms. Hoekenga?

STATEMENT OF SUSAN HOEKENGA, EXECUTIVE DIRECTOR, ELDERHELP OF SAN DIEGO

Ms. HOEKENGA. My name is Susan Hoekenga, and I am executive director of a nonprofit agency called ElderHelp of San Diego, which has been in San Diego for about 20 years. The mission of the agency is to provide services, which prevent or delay the institutionalization of the elderly.

I think there is a special significance for me to be testifying today, October 31, because for the clients that we see and the services that they need, the proposition for the lack of access to health care for them is truly a scary one. So I think your timing is very good today.

I am not going to read my testimony, because it will be entered into the record. But I would like to highlight a little bit about the primary problems that we have seen over the last 20 years are, in terms of access. And also, about some innovative things that are happening at the community level that can address this problem.

And I have to say that Joe is a very tough act to follow, but his comment is a poignant one in terms of financing. Because I tend to agree with him that the solution is not necessarily more money, but an examination of how we can spend the money we have allocated more wisely.

When I thought about the testimony today, I was compelled to remember two women that we had served in the most recent past. One of them is a woman I will call Mary, who is diagnosed with emphysema and an ulcerated esophagus as a result of her treatment, not until she was in her eighties. Because her income was $675 a month, she is over the SSI level, which means that she did not get Medi-Cal. But she, on a sliding scale basis, could provide her share of cost through the department of social services in San Diego County.

She is regularly hospitalized because of breathing seizures, and when she is released home, her dietary needs are such that she cannot receive home delivered meals. She cannot stand long enough to do her own cooking. She is not eligible for in-home support services. After all of her out-of-pocket costs, such as rent, utilities, and this $50 for her share of medical costs, she has very little money left for food, or help to recuperate at home.

The problem is that every time she goes into the hospital, it is at a cost, in California, of about $1,500 a day. So Mary will spend her remaining time bouncing back and forth between the hospital, that cannot really solve her problem, and then back at home, until she gets ill enough to go back and be hospitalized.

The other client I am reminded of is another woman, also in her eighties, whose name is Ann. Her story is a very interesting one. She went into the hospital for eye surgery, and when she was released, she was released with bandages on her eyes, and three different types of medications, all in the same size bottle, all with different dosages.

The doctor authorized her to go into a nursing home, but she had no guarantee if or when she would ever be released. So she took her chance by going home. Because of this, the home health care system would not authorize services. So home she went, with these

three bottles of different sizes and shapes, and bandages over her eyes, so she could not read the instructions.

Her problem was that there were no in-home support services, no medical services, and she was looking at another hospitalization, again, at a cost of about $1,500 a day, until she could receive services in order for her to be able to come back home.

I think these two examples point out three problems that we see with the very low income elderly. First is—and it is impossible to talk about access to medical care for the elderly, without discussing the Medicare system. And I know you have had testimony on that in the past at other hearings, so I will not go into a long discussion of that. But clearly, with low income elderly, it is the biggest health care provider, and it is the one that deserves, I think, the most scrutiny.

The biggest problem that we see is that there is no access to the Medicare system for preventative measures. You cannot have a regular check-up, you cannot receive hearing exams or hearing aids, vision exams or eye glasses. There is no podiatry, and even if there were these services, there is no transportation. And if there was, there is no one to help someone like Ann down the steps, who cannot see to get into a vehicle and get to the doctor's office.

So I think that coverage for preventative measures is something that is critically needed, because at present, we are treating seniors only with the most acute health problems at the most acute level of service, which is hospitalization.

I think that the second problem that this points out is the problem of lack of community based care for essential, but nonmedical, services. We see, quite often, the fact that when seniors come home, the amount of authorized home health care is very limited. A couple of hours a day, or so many hours per week. And those are for things like having their blood pressure checked, or their dressing or bandages changed. But that person is home alone, with no one to provide meals, and do cleaning, and no one to do laundry.

The agency that I work for, ElderHelp, was founded, based on—and, in fact, Joe Stern was one of the founding members. And it was based on the idea that 80 percent of the elderly are healthy and independent, and have the ability to provide the services. But that there is another 20 percent out there that really need that assistance.

So there is a very simple process of reading to a person who is blind, or cooking for someone who is, you know, somehow homebound, and cannot provide the service. The problem is that these are not eligible, reimbursable services. And so, agencies like ours are very limited in what they can provide.

In San Diego there are over three quarters of a million people over age 60. And we serve about 1,500 people per year, on a budget of less than $200,000. This county has two primary funding sources for community based services. One is the Area Agency on Aging, which administers funds under the Older Americans Act, which spends about $10 million in San Diego County. And the other funding source is the local San Diego United Way. The United Way, last year, raised over $25 million in San Diego County, and less than 2 percent of those funds went to provide services for the elderly.

The Area Agency on Aging is its own service provider. It contracts with itself, with county-paid employees, to provide in-home support services at probably one of the most expensive costs that in-home support services can be provided.

So we see that there are some innovative things being done at the local level, but the serious lack of funding is an incredible hamper to being able to really meet the needs of this population. And I guess, my own suspicion is that until we take a more serious look at Medicare and, I have outlined several things that we can do.

One of them is to really examine how the Medicare system works, and what our greatest needs are. And I suspect that if we took a look at instances of acute institutionalization of the 80 and over-aged population, we could see what percent of those people were in the hospital and in skilled nursing care facilities; what percent of those admissions could have been served at a less acute level of cost, had they been allowed to access the system before their condition became that serious.

I think we also need to take a look at the fact that Medicare does not allow essential, but nonmedical at-home services. And as long as that is the case, seniors will be released back to the community without a safety net of services, causing them to re-enter the health care system at the most expensive level possible.

Finally, I think we need to take one more look at Medicare, and we look at a means task. If a millionaire can receive Medicare services merely because they paid into the Social Security system and they have reached age 65, but an 80 year old person cannot go home from the hospital and receive a nurse there to help read her medications, we have got priorities that are out of order in this country.

And in conclusion, I will just say that I think that is nice to be able to come before you and raise these comments. I think that communities do very innovative things. We operate a shared housing program that not only provides services to seniors—medical services to seniors, in their own homes, but links women with children, to be able to go into the home, and provide services for seniors. So I think that we can do some things in this community, and have done some terrific things. But with the aging of the population, the prospect of being able to provide community-based care is a necessity more and more.

[The prepared statement of Ms. Hoekenga may be found at end of hearing.]

Mrs. BOXER. Well, thank you very much for your contribution to this, which was excellent. And I think your specific explanations, examples of people, is very important, because it brings it right home.

I just wanted you to know that in this last budget package, we have apparently extended home care to more people. So I want you to, if you can, in the next couple of days as we begin to unravel the budget package, I think you will be pleased to see that we have done an extension of home care.

Do we have that with us, Lynne? So maybe we can give it to you. Because I think you will see we are moving in that direction. And as I said, we made a stand. And what we got was mammograms,

for the first time, included as part of Medicare. Colon checks included for the first time. And we extended home health care. And we extended Medicaid to people near the poverty line. So we did get a few good things out of the budget fight. And Lynn will share some of those.

I really want to thank you very much. You have been very patient and very good. With that, the Task Force meeting comes to a close.

[Whereupon, at 12:10 o'clock, the hearing was adjourned.]

HEALTH CARE CRISIS: PROBLEMS OF COST AND ACCESS

MONDAY, NOVEMBER 5, 1990

HOUSE OF REPRESENTATIVES,
TASK FORCE ON HUMAN RESOURCES,
COMMITTEE ON THE BUDGET
Sacramento, CA

The Task Force met, pursuant to notice, at 9:05 a.m., in the Board of Supervisors Chambers, 700 H Street, Sacramento, CA. Hon. Barbara Boxer presiding.

Mrs. BOXER. We are fortunate to have with us today two very respected officials, Hon. Ann Rudin, mayor of the city of Sacramento and Hon. Grantland Johnson, chairman of the Sacramento County Board of Supervisors. Madam Mayor, I will turn it over to you.

STATEMENT OF HON. ANNE RUDIN, MAYOR, CITY OF SACRAMENTO

Ms. RUDIN. Thank you, Congresswoman Boxer. It is an honor.

I came this morning not to present testimony but to welcome you and thank you for holding this hearing in Sacramento.

As you know, the cities do not have responsibility for health care, although indirectly we're involved to a very great extent. Still, we think that it's the most critical issue that affects every single individual in our city and we want more attention given to health care when it comes to access, to affordability of health care and availability of health care.

I think that there is no service that requires more attention at this time than the spread of the diseases that are carried by drug use, AIDS, and the problems of seniors in our community who need health care and who cannot afford health care. I think for all of us it's a very critical issue.

I want to thank you for coming. I just want to note you're out of your district the day before an election. I think it takes real dedication—you should be at home campaigning—to be here in our city to hold this hearing to find out what the needs are. And I know that your committee will take our comments very seriously.

I also want to thank Congressman Fazio. This is his district, I guess, but he, too, ought to be walking precincts instead of coming in and attending to our needs. However, I think that shows dedication on the part of both you and I thank you very much for that dedication.

Mrs. BOXER. I thank you so much, Mayor.

Mayor, I will say that one of the things my district wants me to do is my job, and this is my job as Chair of the House Budget Committee Task Force on Human Resources. And what we're hearing—and it's very interesting—all across the State here is the same story about the crisis that health care is in and it just stands for every county in this State, but I want to thank you for being here.

Before I turn to the Supervisor, what I'd like to do now is read a brief opening statement, since yours was more of a welcome, and then ask my friend and colleague, Mr. Fazio, if he has a statement to read.

Again, I want to welcome you all here.

This Task Force is charged with the responsibility of recommending funding levels for health programs and for education to the full Budget Committee. During the 2 years of my chairmanship, the Task Force has highlighted some of our most critical health care needs.

Over the last year, this Task Force has held hearings on AIDS, on Medicare, on biomedical research, on veterans health care and on the Women, Infants and Children program.

The people best able to advise us on health care issues are the people fighting the battles on the front lines, the people we will hear from today.

And that is why we are out here today, to find out how the people in this community are coping, and to identify key problems and perhaps some innovative responses that I can take back to Washington as we begin to debate the next budget.

We are aware of some shocking statistics: As many as 37 million Americans have no health insurance coverage at all. Medicaid serves only about half our poor children, while 20 percent of our children are below the poverty line.

The U.S. ranks behind 19 other industrialized nations in infant mortality rate. And it always amazes me that a baby born in Washington, DC has less of a chance of surviving than a baby born in Cuba. We have 40,000 infant deaths per year. Over 70,000 babies are born every year to women who have had no prenatal care.

These figures are all the more disturbing in light of the tremendous resources we devote to health care. I have long advocated an approach to health programs based on the cost effectiveness of early intervention. We have to reach out to people before they are ill or pregnant or hooked on drugs.

Today, we are bringing together local elected officials, health care providers, and community advocates to dramatize health care issues. Many of these issues that were debated so visibly in recent weeks will be fought again next year. And so we have an early opportunity, Congressman Fazio and I, to send a message that will be carried back to Washington.

At this point, it is indeed my great pleasure to introduce a man who is a true leader in the Congress of the United States—sometimes in your own district people don't know the contribution you make to the institution, the leadership that you give, the way that you can move to bring forward legislation and really make it happen and deliver it to the people who need it. And this is a man sitting next to me who does that each and every day.

And so it's certainly a pleasure for me to be able to say that to you, that we need him in Congress. I can't imagine what it would be without him there, and I know that he will be back to fight the good fight and certainly health care has been one of his issues.

So at this time, it is my privilege to call on my good colleague—a real leader so designated by his colleagues—Vic Fazio.

STATEMENT OF HON. VIC FAZIO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. FAZIO. Thank you, Barbara. I'm not going to make a lengthy statement. In fact, I'll do what we often do, put it in the record.

Mrs. BOXER. Without objection.

Mr. FAZIO. Regrettably, I have to leave before the end of this program and I want to hear as many of my friends and constituents as I can. But let me say I'm sure on behalf of Grantland and Anne how much we appreciate your taking the time to come to Sacramento and listen to our problems.

We are a growing community, one of the fastest growing in the country. And as we grow, we've had the opportunity to have more affluent people become a larger share of our population here in Sacramento, but we've also had a very transient population.

We've had increasing problems of drug dependency and AIDS—we really are a community that is in transition and we have health problems of access particularly and also cost because it is a very heavy burden for our local taxpayers as well as the state.

I can't think of a more appropriate place for you to be having a hearing and, as a member of the Budget Committee some 6 years in the past who has enjoyed sitting with you, I can only say when Barbara Boxer identifies a problem and decides to go out and work on it, the public across the country—not just in your district—is going to come out ahead. You're a dedicated and effective worker for people, and your hearing today is only the most recent evidence of that. I'm pleased to be able to be with you this morning.

[The opening statement of Mr. Fazio may be found at end of hearing.]

Mrs. BOXER. Thank you, Congressman Fazio, so very much for that.

With that, we will turn to our leadoff witness, Hon. Grantland Johnson, chairman of the Sacramento Board of Supervisors. I'm delighted that you made the time to be with us today.

STATEMENT OF HON. GRANTLAND JOHNSON, CHAIRMAN, SACRAMENTO COUNTY BOARD OF SUPERVISORS

Mr. JOHNSON. Well, I'm delighted that you've come to Sacramento. When I first got word that you were interested in holding a field hearing here in Sacramento, I was most excited and then our community got most excited by your presence.

Let me say first of all it's good to see you again. The last time I saw you was, I believe, 2 years ago at a Asilomar. You were speaking before a local government convention. And I've had a chance to observe your task force hearings on C-SPAN in terms of dramatizing the issues in terms of how we allocate resources in this country, on what basis and how we set our priorities.

Let me also echo your comments regarding Mr. Fazio, who I happen to have known for a number of years. A lot of us have known Vic Fazio from his early days in the State assembly both as a member and as a staffer. And I can tell you as an elected official that we recognize him to be true leader in Congress. We happen to have the privilege of having him in our district and so we have a unique opportunity upon which we have people that can work together.

I just briefly wanted to outline a couple of things that I know your task force is going to be dealing with and we have many good experts coming subsequently before you as members of panels. But I want to point out a couple of things that we discovered here in the county and the staff people who have pointed that out.

When you look at the health care, Sacramento really suffered a burden from the standpoint of people's inability to gain access financially to health care services. My understanding is that something like 26 percent of the State's population is comprised of folks who don't have access to basic fundamental health care services.

The Women, Infants and Children program is a good example. It affects us. While the program allows services for children up to 4 years of age, because of underfunding, we have to restrict services to pregnant and breastfeeding women and children up to 12 months.

Costs affecting us in this program have already clearly been demonstrated and proven beyond doubt that for every $1 expended, $3 are saved in Medicaid costs for newborn intensive care alone; plus the cost to Sacramento County alone, because of the program, is 240 percent lower than would be the cost of a fully funded WIC program.

When you look at the fact that we could do more in terms of preventing diseases, we have grossly underfunded immunization. The county has to constantly get the vaccines and unfortunately because of fund limitations, we don't have a good outreach program in this area for preventive vaccinations.

So when you look at the fact of accessibility, you come up with the notion that basic public health funding is inadequate, services such as outreach, home visits, preventive education, are not available except in small categorical programs.

You look at Sacramento and I think the area of greatest poverty, the areas of concentration, where the bulk are served, such as Del Paso Heights, Garden and you've got the worst health care emphasis. In these areas, we have the fewest medical facilities, so the historical maldistribution of primary care physicians is still a constant factor. We evaded this issue back in 1975, 1974, and it still has not been addressed adequately.

We face, for example, problems with dental services. There's nothing available to the Denti-Cal patients due to the low reimbursement rates. Dentists just don't want to touch it. And there severe, severe problems in terms of preventable health care diseases and maladies that simply are not dealt with because they have no access.

It also is a problem which is both urban, suburban and rural. It has geographical areas where people reside because they simply cannot get access to health care services. So when you look at rural

America, you also have to look at Sacramento County in terms of rural visits and the ability to get primary care services.

And if you think in terms of health care, you have to look at other contributing factors: the fact that one out of two marriages end in divorce in our community; over one-third of children in Sacramento County under the age of 6 lives at or below the Federal poverty line.

Mrs. BOXER. Would you say that one more time?

Mr. JOHNSON. Over one-third of the children in Sacramento County under the age of 6 live at or below the Federal poverty line.

Between 1982 and 1986 in this county, IV drug use increased 70.5 percent in Sacramento, whereas statewide it increased 23 percent.

Referrals of drug addicted infants to children protective services increased more than 10 times to an average of 40 children per month in 1988 and reached a high of 61 and 62 in mid-1989. Early 1990 data is showing a decline to an average of 22 per month but while there is some hope that substance abuse programs will have a positive impact, I should point out that the figures I just read are somewhat misleading, as these figures do not accurately reflect those children born with fetal alcohol syndrome, which physicians and other experts is part of what they see as a long-term health problem.

For the most part, if an African American male reaches the age of 18 months, they are virtually never adopted. There's a recent report issued called 50 Reasons to Invest in Families of Southern California. In that report, African American children represent 26 percent of our county's population, but they currently receive only 16 percent of funds allocated for help. The reality is a that what's taken from one part of our population which is very vulnerable is moved over to another part of our population.

And we're having to make a hard decision—do we address the problem of acute care or personal health care or mental health care? Or do we invest more money at the expense of home care or attendant care in order to be more cost effective rather than emphasizing prevention and early intervention?

And we know the tragedy—that early intervention actually works. It really does work. And yet we've got to make the kind of commitment that's necessary. I think that says a lot about where we are as a country, as a state and as a community. We have not made the commitment necessary to use our funds more prudently, more effectively.

It is better to address the early stages of our population as opposed to the later stages. It is better to address in young kids who because they're born couldn't even sit here and witness this conversation because they're so strung out. Because they're so addicted. That's a tragedy.

And again, as a member of the board and on the part of my colleagues, we're extremely grateful that you're here, extremely grateful that you're going out and seeing what we see every day. And this will illuminate in even much more graphic detail what I've only very cursorily covered, sort of given you a glimpse of the fact that Sacramento County is a part of the mainstream issue of lack of resources that exists with the rest of the State and the Nation.

So thank you very much.

Mrs. BOXER. Mr. Chairman, let me say that your testimony is very important to this Task Force because what you have put into your opening statement is what I've been trying to get across to the Budget Committee and Mr. Fazio and I to our colleagues.

I think when history is written it will be said that the eighties was the decade that America forgot its children.

Mr. JOHNSON. Absolutely.

Mrs. BOXER. And we can't forget our children. Because if we forget our children, we're doomed as a society. You have brought that home by stressing the condition of children right here in this county. A third of the children live at or below the poverty line—one out of three children here. Only 20 percent who are eligible are receiving nutrition supplements from the Women, Infants and Children program.

Mr. JOHNSON. Which is lower than what other communities are——

Mrs. BOXER. Yes.

Mr. JOHNSON. I saw a hearing—I believe you were a participating individual on it.

Mrs. BOXER. Yes.

Mr. JOHNSON. It was 33 to 36 percent of the—and that's tragically low. And embarrassingly low, that we're only able to do about 20 percent. That even includes from last year's budget, where we augmented the budget. It made a difference. The frustration is that you know you should be doing more but you can't do more.

Mrs. BOXER. What I'd like to say is that this has to be on our shoulders. The WIC program is a Federal program. We've got to get milk to these women and cheese to these women and to these babies. Period. And we're going to be facing it again, I say to my dear friend, because the formula companies are playing real games with the pricing and we're going to need to be sure that we serve these children.

As you pointed out, this is a cost effective program. There isn't even an argument from the most conservative right-wing member of Congress. They all agree that the money that you save by investing in a feeding program for pregnant women and their kids comes back to you threefold, probably tenfold.

So we certainly have the economics on our side. We just need to make the priority point. And so I say to people who really may not feel in their heart that we need to take care of kids that they should look at it from a very cold economic perspective.

First of all, we take care of them early, we save money. Second of all, we take care of them early, they become productive members of society and instead of going to prison, instead of winding up at a mental health institution, they're going to have a good job.

As we look ahead, the year 2005, which is right around the corner, pretty much, we're going to see a work force where the eligible work force will only be 15 percent white male. So we're looking at women and we're looking at people of color filling our work force.

And as we follow these problems, as you point out, most of the kids who are in poverty here, not a majority, but 46 percent, did you say, are Afro American?

So we have a job to do and we need to do it not only in terms of human compassion and caring, in looking at an innocent baby—my God, how could anyone in this country feel that that innocent, vulnerable baby doesn't deserve every shot in the world? Just because he or she does.

But more than that, the economics dictate that if we don't give that child a shot, the whole country isn't going to make it in this new economic competition we're in. We're really finished with the cold war. We're in an economic war, and we're not going to even come close to competing if we lose our kids.

And what you have done is that you have pointed out very clearly, very specifically how we're losing our kids in this community. And believe me, your words have been echoed in five other hearings that I have held, from Washington, DC to Fresno, Modesto, and all through the state.

I would like to, with Mr. Fazio, be able to put your testimony in the Congressional Record when we do go back. We're assuming we'll be there and able to do that. So——

Mr. JOHNSON. Safe assumption.

Mrs. BOXER [continuing]. So we're hoping we can do that so that our colleagues can not only get this in the hearing form but they can see your comments in the record because I think it's a very important overview of the status of children in this county.

Mr. JOHNSON. I will also be providing a written copy of it for the record and it will be translated.

Mrs. BOXER. Well, that makes it even easier for us to put it in the record. Thank you very, very much. And I would call on my colleague.

Mr. FAZIO. I will only make one comment. First of all, Grantland, thank you for doing such a good job of putting it all in perspective so briefly for us.

You know, the states do have a potential role here. New York State has been spending a sizeable amount of money to provide outreach and they end up with a WIC participation rate of well over 50 percent as a result of that.

The State of California, which really has the resources that many other states don't have, has an abysmal rate of participation because we don't put up one dime. And if our State leaders would become involved in an outreach program, they could have so much Federal money flow into this State for this very beneficial purpose, but they've chosen not to do it.

I don't think the counties generally, particularly given what they are able to get from the State budget at this point in our history, should be looked to as the source of an outreach program. I'm pleased that you've supplemented the funds here locally. But it really should be the responsibility of the State of California to help bring our WIC participation rate across the State up to at least 50 percent.

Mr. JOHNSON. I would like to make one point regarding this question of the relationship between the State and local government. Our county executive did a workshop 2 weeks ago on this whole question. He made a very important point during the course of that discussion. If the state could just simply keep up with the statutorily required match, we wouldn't have to overmatch, that is,

put in much more money over and above what our statutory overmatch requirement is. What that does and it covers so much money that we're unable to redirect those funds into other areas where service is needed such as outreach for example.

But there are also mandated requirements for the State to fulfill its statutory obligation which forces greater commitment of additional moneys on the part of the Government and then against all of that, there is no real commitment to supplement what they ought to be doing as a State.

You're absolutely right—the area of increased resource allocation for the State and No. 2, working with the Federal Government to give us greater flexibility in terms of utilizing our resources. If we had the ability to co-mingle categorical funds, we could deal more effectively with transients who have multiple problems. We have multiple agencies—county agencies, state agencies, and the tragedy is that there's just not enough money in each categorical program.

We'd be better off if we had the ability to concentrate those program funds and responds to a multiplicity of problems.

On the question of housing, question of transportation, we could have a much more beneficial impact in terms of bringing these folks back into our mainstream from the marginalized programs and when you talk about the vast numbers of work force entrants by mid-1990's, it won't be competitive. Workers are going to have to change careers two and three times.

I should stop and let you move on to the next panel.

Mrs. BOXER. Yes, Madam Mayor. Thank you both very much for your participation. We thank you so very much for your testimony.

Mr. Fazio Did you have any other questions?

Mr. FAZIO. No, that's fine. Let's go right ahead.

Mrs. BOXER. Okay. We'll go on right away to the next panel: Ronald Usher, who is, director of mental health in Sacramento. I know Ron from his days in Marin. It's nice to see you; Randi Harry, associate director, Hospital and Clinics, UC-Davis, Medical Center; and Len McCandliss, president the Sierra Foundation. We're very pleased that you're able to join this panel. Thank you. And Len, when you do that, I wanted to see you for just a moment.

What we'd like you to do is to try and summarize your written statement if you feel comfortable doing that and try to finish between 5 and 7 minutes of a presentation and then we'll have more time to ask you questions. Ron, why don't you proceed.

STATEMENT OF RONALD K. USHER, Ph.D., DIRECTOR OF HEALTH AND MENTAL HEALTH, SACRAMENTO COUNTY, CA

Mr. USHER. Thank you very much. It is indeed a pleasure for me to be here and address with you the problem of health care costs and access issues. My perspective of course is from county government. Since leaving your former employ in 1978, I have served as the director of the Sacramento County Health Department. We're responsible for public health, medical and mental health and substance abuse services in a growing urban county of over 1 million people.

As you know, Sacramento is the hub of a much larger region. Various of our medical services located here draw patients from adjacent and distant areas populated by another half a million to a million people, depending on services. So what happens here in Sacramento is vitally important to people who reside in or travel throughout northern California.

Supervisor Johnson gave you an excellent overview of the various issues that you will be hearing more about today, and I'd like to focus on two of those that are particularly compelling.

I'm going to offer some comments on the worsening crisis in emergency medical services and then I'd like to discuss the plight of medically indigent persons, including those who must rely on California's failing Medi-Cal program.

Emergency medical services in Sacramento County are now receiving a lot of attention. Identified problems include a disorganized system of ambulance response involving seven separate private companies and some local fire agencies. It is an arrangement which was established when Sacramento was less populous and current complexities of congestion were not evident. Ambulance response time now frequently falls below acceptable standards.

The system relies on an archaic communications system which needs major overhaul. These are problems which can be addressed, but only with resources which we have yet to identify. Furthermore, our problems are not limited to pre-hospital care. We face serious issues of accessibility at the 11 hospitals in the Sacramento area.

There is no county hospital in Sacramento County. The University of California, Davis Medical Center provides significant emergency and indigent care services. It is our only trauma center, drawing patients from a vast geographical region. As such, UCDMC experiences recurring overloads.

Recently, an internal disaster was declared to facilitate the moving of patients so that the door for new trauma patients would remain open.

The other local hospitals provide basic emergency services and all of those within the county boundaries except for two Kaiser facilities have contracted with Sacramento County to provide indigent care.

In recent years, it has become clear that hospital-based emergency care is not adequate to meet the demands of our growing population. Diversion of ambulances did not happen a few years ago. Now, it is a daily occurrence for other than immediate life-threatening cases. The hours of diversion are increasing each year.

It is not unusual for several hospitals to be on diversion status at the same time. If this trend continues, there is no doubt that death and serious disability will result when people in ambulances cannot access essential hospital-based care promptly.

Reasons for ambulance diversions vary. Some hospital emergency rooms are too small; other facilities lack capacity elsewhere on the premises so patients on gurneys fill up the emergency rooms. There are medical specialist shortages in some fields and geographical areas.

While these explanations differ, one overriding conclusion is inescapable: Present incentives in the health care system do not en-

courage those who make private sector decisions to address the problems of public access to necessary health care. Although economics are certainly involved here, we are not talking solely about serving indigents. Emergency medical care access is an issue for everyone.

If the facilities and resources are not there when they are needed, it doesn't matter how much ability a given patient has to arrange for payment. This is a major community problem which Sacramento County is trying to address, but our efforts to find solutions are constrained by the fragmentation, lack of resources, and perverse incentives in the total health care system.

Shifting focus to indigent care, let me offer a brief review of another worsening situation. The plight of the uninsured is now well known here in California as it is elsewhere.

Various reforms have been proposed but nothing meaningful has been enacted to relieve the increasing burden on the people who need to be served and on the counties as providers of last resort.

Here in Sacramento County, we opposed the shift of the non-federally funded medically indigent adults from State to county responsibility in 1982. We found no plausible justification for a public policy which guaranteed that indigent people would be treated differently depending on where they lived.

Losing that battle, we then set about to create a managed care system which has received national recognition. It provides necessary care to those who need it through a combination of county and private provider services. It continues to assure access, despite depletion of state funding.

That has been possible because the Sacramento County Board of Supervisors has used local tax money to backfill horrendous State budget cuts which could have decimated the program.

Only a few weeks ago, our Board chose to cover the latest $6.5 million cut with virtually all of the local revenue which otherwise would have been available to expand other public services in a rapidly growing county.

This happened because the threatened medical service reductions would have reduced available indigent care services to only the direst emergencies. Our Board would not accept that alternative as befitting a civilized society.

Although our indigent care program has survived for now, we are worried about the future. Indications from State government are that next year will be much worse.

Beyond the county problem, there is another level of increasing concern. California's Medi-Cal program is rapidly deteriorating. Here in Sacramento, county responsibility medically indigent persons now have better access to care than do many state responsibility Medi-Cal patients.

We know that because we see increasing numbers of Medi-Cal patients at our primary care clinics—patients who require specialty services which our clinics do not provide. These patients come to us because they cannot find private sector specialists who will treat them at Medi-Cal rates and under the bureaucratic processes of the state program.

I am referring here to pregnant women who cannot obtain prenatal care, who will show up at hospital emergency rooms when

they are ready to deliver. I am talking about Medi-Cal eligible persons who go to emergency rooms for stabilization of broken bones, but who cannot find orthopedists for follow-up care.

Dentists in this community will not accept new Medi-Cal patients because the reimbursement level is so low that they cannot even cover the laboratory costs of a typical patient visit.

One-third of the admissions to our psychiatric health facility are Medi-Cal eligible persons who we serve without reimbursement because they cannot access services elsewhere.

What might the U.S. House of Representatives do about these problems? The Federal Government is a partner in the Medi-Cal program. Access to health care is a matter of national concern. The problems are worsening. All variety of solutions have been suggested.

It is time for dialog to be concluded and for Congress to enact a comprehensive approach which promises to address the issues rather than continue to avoid them. Without such action, the crisis will surely get worse.

Thank you for inviting my participation in your consideration of this important matter.

[The prepared statement of Mr. Usher may be found at end of hearing.]

Mrs. BOXER. Thank you so much, Ron, for those very important words. I will come back to you with some comments and questions.

Randi Harry from the UC-Davis Medical Center. I guess you are really on the front lines here, after what Mr. Usher has said and we look forward to your testimony.

STATEMENT OF RANDI L. HARRY, ASSOCIATE DIRECTOR, HOSPITAL AND CLINICS; DIRECTOR, FINANCIAL SERVICES, UNIVERSITY OF CALIFORNIA, DAVIS, MEDICAL CENTER

Ms. HARRY. Thank you. Chairman Boxer, Congressman Fazio, thank you for the opportunity to share my views on the problems of cost and access in health care today.

I'd like to focus on really three issues. The first is the increasing share of our national resources devoted to health care, the second is the distribution of health care dollars, and finally, the impact that those cost factors have on access to health care.

I believe there are six reasons why we can expect to see continued increases in the share of resources devoted to health care.

The first is the aging of our population. Patients over the age of 65 use about four times the health care resources used by patients under age 65 and those over the age of 85 use 2½ times the amount used by those between the ages of 65 and 69. And a larger and larger share of our population is moving into those age groups. The amount of resources demanded will continue to increase.

The second reason is the increase in technology. It's true that new technology has had a very positive impact on our ability to extend life and to provide health care services to patients who might have died a few years ago, but it's very expensive.

For example, a new drug, Tissue Plasminogen Activator—otherwise known as TPA—a genetically engineered drug, provides improved care for patients suffering from heart attacks. But one dose

of that drug costs $2,200. It becomes very difficult to make that kind of care available under some of the current reimbursement schemes.

But in order to remain competitive, community hospitals as well as teaching university hospitals must offer the latest technology in order to attract both physicians and patients to use their facilities.

A third factor in the increasing cost of health care is the prevalence of new diseases. The AIDS epidemic has been well documented. In addition, there are new varieties of old diseases that have developed resistance to some of the drugs that have been very effective in the past. We're now facing a new staph infection that is resistant not only to penicillin but to an improved version of penicillin that was developed to deal with those bacteria that have become resistent to penicillin.

We've had patients who have spent 3 and 4 months at our institution as a result of the resistant bacterial strains that really are very difficult to address with our current pharmaceutical army.

In addition, we are a nation of a variety of social diseases. We are a nation of a variety of addictions including drug and alcohol abuse. They are not only physically damaging to the user but they also place other burdens on the health care system. There are automobile accidents and a need for trauma care; drive-by shootings, domestic violence, birth defects and the impact on children who are exposed to drugs during their mother's pregnancy.

In addition, a breakdown of the family has left a number of elderly Americans without family resources and dependent on the health care system for long-term care and other health needs.

In addition, from the standpoint of a health care provider, a factor is the shortage of health care personnel. The nursing shortage has been well documented and has received national attention, but we face similar shortages of occupational therapists, physical therapists, pharmacists and other health care professionals. And, in a supply and demand economy, when there is a shortage of a particular kind of personnel, hospitals are forced to offer higher wages to attract those individuals who are necessary to provide quality services.

And finally, and I think most importantly, the physician incentives in our system do not encourage the cost effective utilization of health care. Physicians are generally economically compensated at a higher level for providing more rather than fewer services. In addition, the fear of malpractice litigation has led many physicians to overtest and overprescribe to protect themselves against the specter of a very damaging negative malpractice verdict.

Hospitals do have some control over what it costs to provide each unit of service. They have virtually no control over the number of units of service that are provided to an individual patient, whether that's days of care, X-ray tests or prescriptions. Those decisions are in the hands of physicians and most of our present incentives really do not address the cost-effective utilization of health care in that arena.

The second issue I'd like to address is the relationship between the share of costs that are carried by the public sector and the share carried by the private sector.

The Medi-Cal program, as Dr. Usher has already mentioned, in California is rapidly failing. We have a selective contracting system supposedly based on negotiations. In fact, the negotiations consist of the State negotiator describing a rate which is the most the hospital will be allowed and an indication that your only real choice is to participate in the program or refuse to participate.

At UC Davis Medical Center, for example, over the fiscal year ended June 30, 1990, we lost $47 million providing care to Medi-Cal patients, who represent about 44 percent of our patients.

Turning to the Medicare program—when prospective payment was originally introduced, the intention was that the cost or the rates paid to providers would increase at the same rate as the marketbasket of costs that those providers incur. However, in an effort to both force providers to be more efficient and to help to balance the Federal budget, the rate of increase in Medicare payments has actually lagged 1 to 2 percent behind that marketbasket increase, to the point where California hospitals, for example, now receive only about 92 percent of their costs for the services that they provide to Medicare patients.

Again, using UC Davis Medical Center as an example, we lost $1.6 million on Medicare patients in fiscal 1990. Had we not been a teaching hospital receiving some of the allowances that are made for teaching hospitals, that loss would have been much greater.

In addition, of course, those patients represent only about 18 percent of our patients. So we're losing a large amount of money on a relatively small group of patients.

The Medically Indigent Services Program referred to by Dr. Usher was cut dramatically in 1982 when the State transferred responsibility for this population to the counties. Again, year after year, we've seen budget cuts in that program to the point where most providers also lose money on providing services to MISP patients.

In addition——

Mrs. BOXER. What's MISP?

Ms. HARRY. Medically Indigent Services Program. It's the county program for the working poor, for medically indigent——

Mrs. BOXER. People who have no coverage whatsoever.

Ms. HARRY. That's correct.

Mrs. BOXER. They don't have insurance, they don't have Medi-Cal.

Ms. HARRY. That's correct.

Mrs. BOXER. Okay.

Ms. HARRY. There is yet another category of patients who do not qualify for the MISP or Medically Indigent Services Program who have no insurance, who have no Medi-Cal. That group of Californians represents about 5 million people or 21 percent of the population. They also face the same kinds of problems that Medi-Cal and the MISP patients have in receiving services.

Again, at UC Davis Medical Center, we collect about 8 cents on the dollar from that group of patients. A few of them do make efforts to pay. But in general, we collect only 5 percent of the cost of caring for those patients.

The impact of these reimbursement shortfalls is that access to care for a whole variety of patients is restricted. Physicians in pri-

vate practice find both the reimbursement levels and the billing requirements of Medicare—and to a much greater degree Medi-Cal—so onerous that they often refuse to accept Medi-Cal patients.

The perception among physicians is also that this group of patients tends to be more litigious than the average group of patients. In fact, there is some research which suggests that that may not be accurate. Nonetheless, I believe that physicians' behavior reflects that belief.

The patients do tend to be high risk. They are often poorly nourished, they are often less compliant. Because they don't have access, they are often more seriously ill when they do finally enter the health care system.

In addition, many patients fail to accept responsibility for their own health. And I think obstetrics, which will be addressed, I believe, by later speakers, is one of the most graphic examples.

The perception is often that when there is a bad outcome, when a baby is born who is not as perfect as the parents would like it to be, that the obstetrician must have done something wrong.

It's gotten to the point where the malpractice premiums for obstetricians have increased dramatically and many obstetricians and gynecologists are choosing to restrict their practice to gynecology alone and are no longer accepting obstetrical patients because of those malpractice rates.

Now, when you cannot find an obstetrician, you have a situation like the figures for our emergency room reflected last year, where 23 percent of the mothers who delivered at our medical center had no prenatal care at all. They first appeared at our emergency room in active labor.

I believe one of the important things to recognize about Sacramento which is different than both the national picture and the California picture as a whole is that our hospitals here are full.

In California, hospitals operate at the average of 64 percent occupancy. There's only one hospital in Sacramento that is even close to that rate. The remainder of the hospitals are running between 74 and 85 percent occupancy. And it's also important to recognize that at 85 percent occupancy, we have patients in the hall. The need to separate male patients from female patients; to separate obstetrical patients from pediatric patients from psychiatric patients means that at 85 percent, a hospital is full. We don't have room to accept additional patients.

As Dr. Usher mentioned, we were forced not too long ago to declare an internal emergency, an internal disaster, and turn away all but the most critical trauma patients because we did not have the facilities to take care of the patients that we were obligated to care for as the only designated trauma center.

We were turning away trauma patients, but not the most critical trauma patients. It would, however, only have taken one major accident, one major fire or some other kind of disaster to put us over the edge to the point where we would not have been able to take care of critical trauma patients.

If a hospital has done all they can do to increase the efficiency of the operation, if hospitals have raised their charges to private patients to cover the shortfall from governmentally funded patients as far as they can, if we slash staffing to the point where we can

barely function and we still can't recover our costs, then we need another alternative. I refuse to believe that rationing of health care, that a system that says that when you're over the age of 65 you are no longer eligible for kidney transplants even though you may die without that operation is the only answer. I believe we can find another answer that will address the problems in our health care system through restructuring of incentives and through an approach that recognizes the various needs of our population for health care services.

[The prepared statement of Ms. Harry may be found at end of hearing.]

Mrs. BOXER. Thank you very much.

It's our pleasure to hear from Len McCandliss now, president of the Sierra Foundation.

STATEMENT OF LEN McCANDLISS, PRESIDENT, THE SIERRA FOUNDATION

Mr. MCCANDLISS. Good morning. Thank you for being here and conducting this session.

The Sierra Foundation is an independent private foundation with a mission of funding health and health related activities in northern California. The perpetual endowment of the foundation allows for about $4 million to be spent each year in support of that mission.

Our grants have been very broadly applied. Currently, we have two areas of concentration. The areas of AIDS and prenatal care access are very different but the issues were selected by our board nearly three years ago because of different reasons for each.

The high infant mortality rate for some of the counties in our region would not allow us to turn away. To address those statistics, we have focused upon improved access to prenatal care as having the greatest potential for positive impact. The grantees have responded with energy and innovation and have developed programs that we believe deserve the consideration of government as permanent policy.

When we viewed the AIDS epidemic 3 years ago, we saw the potential for the development of a response system that would be unique to our region. Because of our proximity to an epicenter of the disease, and a relatively high incidence of IV drug users, it seemed that we were particularly vulnerable to high rates of HIV infection.

Our approach has been to support the development of a social work case management model that is dispersed throughout the region.

With that brief history as a backdrop and a reminder that we have been actively involved in providing grants to these programs for only a few years, let me address the purpose of this hearing in terms of access and cost.

The Sacramento region may look like a lot of other regions in the country, and it may be difficult to make the case that there are peculiar aspects of this region that deserve separate—that are not deserving of general Federal policy.

But there are some things that we do know about the region that may be important:

We know that the people in this region feel much the same as the rest of the country about vital issues affecting health care: 92 percent agree that in the U.S. people should receive basic health care, even if they can't afford to pay for it themselves; 76 percent agree that as taxpayers, they would vote for public programs to provide prenatal care for women even if they cannot pay for it; 74 percent agree that tax dollars should be used to prevent disease rather than to keep patients alive for a longer time; 71 percent agree that people who smoke or drink should pay higher insurance rates. (Tomorrow, we'll find out when they go to the polls if they believe those folks should pay higher taxes as well.)

In these issues of access, there is widespread agreement. In other issues, such as surrogate motherhood, AIDS policy, rationing of health care, there is less agreement. But the work that has been done here on these issues indicates that the environment does exist here for coherent widespread debate on public health policy.

We know that there are indicators of declining access to care. For example, there has been a 13 percent reduction in the number of physicians practicing obstetrics in the region in just two years. Standing alone, that is a very disturbing statistic. But if this is a leading edge indicator of general access to care, it is even more ominous.

We continue to hear concerns about the drain of qualified medical personnel who are recruited into "closed" health maintenance organizations.

We know that in spite of many efforts to improve the eligibility process for Medi-Cal it remains a deterrent to the client.

And we know that the state has made improvements in the Medi-Cal payment process, but providers still refuse to see Medi-Cal patients because of a perception that the payment is marginally worth the administrative effort.

With regard to costs, the search for the real culprit in the mystery of spiralling costs of health care continues. I don't think I can add much to the debate except to say that like Pogo, "we have met the enemy and—come to realize that—the enemy is us."

No single element in what some choose to call the health care system is responsible for our growing burden; neither can any element avoid the obligation to act responsibly in looking for solutions.

To draw recommendations from our brief history is difficult but it is necessary. The board of directors of our foundation demand that we do it and the public should expect that our tax-exempt status will contribute to the public's knowledge in those areas where we work.

As you consider policy, please consider some of the following notions which we believe have merit:

Within the rural areas, promote the development of regional planning and delivery of health services;

Develop programs that provide incentives to those who need care the most. If prenatal care is as cost effective as is claimed, then why not add to those programs to provide small tangible incentives to those most in need of care;

Recognize that ultimately we will discover the limit of health care spending and that hard decisions will need to be made regarding what care will be provided and to whom; find ways to test models such as the Oregon Plan in other areas utilizing other fundamentals;

Consider the reintroduction of programs such as the National Health Service Corps that will encourage providers to work in underserved areas;

Develop and support training programs to upgrade the service capacities of physician-extenders, such as nurse practitioners and physician assistants;

And finally, accept that health care and health policy cannot be developed and evaluated without examining broader societal issues such as economics, education, housing and even law enforcement.

Thank you for providing me with this time.

[The prepared statement of Mr. McCandliss may be found at end of hearing.]

Mrs. BOXER. Thank you very much. I really think that it is laudable that there is a private foundation out there trying to fill in some of the gaps. Obviously, you don't have the resources to do as much as you would like to do. But having come from a local board of supervisors, Marin County, for years, I know how important private foundations can be in helping at least fill some of the gaps.

Let me just quickly say this: Both of you have presented—not counting our foundation person—a very bleak picture of what is happening here and I guess—again, I have heard it repeated in so many places—I was in San Diego last week and there heard from an emergency room physician exactly what you said, Ron: that people are using emergency rooms as their only access to health care; be it a pregnant woman who stands there waiting for the labor pains to start so she'll have some help giving birth to this child, or people who have absolutely no health care, have abdominal pain, go into the emergency room, and this is a very telling point that he said, he has been following what's been happening in Los Angeles and San Diego and they found out—they tracked the appendectomies that have been done through a visit to the emergency room and they found out that 40 percent of these appendectomies come after the appendix has ruptured because what has happened is that people are coming in with abdominal pain so they're not considered that much of an emergency so they're told to go home or sit around and by the time they come back, they require this very difficult operation and I know the costs are much higher when somebody's appendix has burst and it become a real critical emergency.

So the picture that is being painted for me as I go around the State seems to be that the health care system is at the breaking point.

And I don't want to overstate it, but when I put together Ms. Harry's comments and Dr. Usher's comments, the picture I'm getting is whereas the hospital used to be able to transfer the cost to the private patients, right now, because you're losing on Medicare now, which you never used to be, you're losing heavily on Medi-Cal, the indigent patients are practically—you don't get anything for—that leaves you the one pool of paying patients and I just have to

make this point—I think taxpayers are going to wake up and understand that they're paying through the nose for their care to pay for everything else. So it isn't—somebody is paying the bill.

But it gets to the point where it's just going to break down because our health insurance, those of us who pay it, it's just going to be out of reach.

So I guess my question to both of you, and I don't want to put you on the spot, but I want you to step out of your seats for a minute and just advise us. Is it fair to say that you feel this thing is at the crisis level and may not be able to continue? And if you think that, what's the first thing that Vic and I should do when we go back?

Mr. USHER. I'll start. I do indeed believe that you have characterized it correctly.

This past month, I had gone to each of the CEOs, chief executive officers, of the various hospitals in Sacramento County to speak with them on the invitation of the board of our supervisors about the emergency medical care crisis and about the need for additional trauma centers.

And although I believe we will get some community cooperation, these institutions and organizations do have a community spirit about them as well as their main mission of providing direct patient care, the message comes back over and over again that the way the system is presently structured, or the nonsystem, there is no incentive for people to get involved and do anything extra.

I don't have any doubt at all that the Sacramento area will confront perhaps revenue bases, local revenue bases, and so on because we can't rely upon the state or turning to the Federal Government to solve these problems at this point.

But I think we are at the stage in the state where we're almost to the collapse point because we have here in Sacramento some medical and health care organizations that are very healthy. They are prosperous in a sense. They do wonderful things. But the incentive for them to do the things that they do—they obviously have to do the things that they do in order to stay in business. If they go out of business, they're not going to provide any health care to anyone.

Mrs. BOXER. So somehow we have to offset the heavy losses that are coming from these non-insured people.

Mr. USHER. Right. Yes. I don't know exactly what your formula will be—there have been so many things that have been written and debated about it, but some way you need to address the question of how do we turn these incentives around and obviously that's a very controversial thing to consider in our society. But we must be able to do it because if we don't, the whole system frankly is going to collapse.

Mrs. BOXER. Ms. Harry?

Ms. HARRY. I think from our perspective, the underfunding in the Medi-Cal program is a greater problem than the uninsured.

We have about 17 percent of the licensed beds in Sacramento County, and provide about 46 percent of the Medi-Cal patient days of care. Largely because we are a trauma center, with physicians on duty in the emergency room, it is easier for Medi-Cal patients to access our system than it might be to access some of the other hos-

pitals who do not have the same constellation of physicians available.

We also operate a whole series of outpatient clinics that are more accessible to indigents than others.

Mrs. BOXER. What percentage does Medi-Cal cover of your costs?

Ms. HARRY. Fifty-nine percent.

Mrs. BOXER. They cover 59 percent and Medicare 92 percent. Okay.

At this time, I would like to ask my colleague to go over with you some of the things we did do in Congress in that budget agreement that may be some source of comfort.

So, Congressman, why don't you go through that.

Mr. FAZIO. Thank you, Barbara.

There is always a tendency at these hearings to rightfully decry our inadequacies and our inability to meet needs, but I think we need to give some credit occasionally to people like Congressman Henry Waxman, who was instrumental in including in the package some things that ran against the grain of budget deficit reduction but which did begin to treat some of the problems that you've identified here today.

When I add up the amount of money we'll be spending over the next 5 years, it isn't going to knock you out of your chairs but we're getting close to a $2 billion expenditure in the next 5 years for such things as expansion of Medicaid coverage for children and adolescents under 19; additional benefits for pregnant women and infants; and the protection of low income Medicare beneficiaries.

These programs will add up to a great deal; in fact, the Medicaid coverage for children under 100 percent of the poverty level will cost about $1.1 billion over the next 5 years. That is an estimate—it may be more than that. Of course, it does trigger some additional State funding as well when you're talking about Medicaid or Medi-Cal in California.

We're also attempting to fund additional programs for the frail elderly and in-home and community-based service programs. We also have some demonstration grants for uninsured families.

That's obviously just an effort to try to find some answers—$40 million doesn't go a long way. And there are some AIDS demonstration projects as well, which we'll learn more about in a few minutes—that are vastly inadequate when we talk in terms of $30 million. But at least we try to come up with some models by which we can more efficiently and effectively provide some additional care for the neediest in our society.

I think the most important thing is that there are a lot of people in Congress who realize the inadequacies of our existing programs. We were also pleased to see, for example, a mammogram component, a $1.5 billion program, included in the Medicare portion of the bill through the good work of Congresswoman Mary Rose Oakar of Ohio.

So we are attempting, fighting against the current, to provide funds for programs that I think we all would identify as very real needs. And yet I can tell you, as Barbara can, having been back in the district for the last week or so, we're being pilloried for raising revenues, even though that's only 30 percent of the package which includes 70 percent spending cuts.

The people seem to identify these problems and then somehow lose any confidence that anything Government can do about them will be of any utility or value.

Barbara and I are convinced that there are things we can do. We wish we could do them more amply, but we are pleased to say that at least some of them have been addressed.

Mrs. BOXER. I really want to thank you for doing that because I think Sacramento County ought to sit down pretty soon with Vic's staff and try to figure what this all means to you. And I think we used the breakdown after the summit agreement to try to leverage what we could for some of these important programs.

Mr. FAZIO. Well put.

Mrs. BOXER. And we did leverage. We did. And we did get some good things and that's very fortunate.

Well, I want to thank this panel. You have given us the overview we need and now we're going to go into an issue that actually has never been the subject of a Congressional hearing that I know of, and it's women and AIDS and I'm very excited about the panel that's about to come forward.

I want to thank you all for being here.

And while you're coming forward, Mr. Fazio and I are just going to have a brief conversation for two minutes and we'll be right back, so take your seats and we'll proceed with the panel on women and AIDS.

[Discussion off the record]

Mrs. BOXER. We are back and I am very delighted that you've come forward today to address an issue that is not getting enough attention, either in the State of California or in the Nation as a whole, and that is women and AIDS.

And I want to welcome the panel: Dr. Flynn is not here, so we have Ms. Casady and Ms. Burnett and Patty Blomberg. Is that correct? Did I say it right?

Ms. BLOMBERG. Right.

Mrs. BOXER. Why don't we start with Ms. Casady, executive director of the Chemical Dependency Center for Women. We welcome you.

STATEMENT OF CAROL CASADY, EXECUTIVE DIRECTOR, CHEMICAL DEPENDENCY CENTER FOR WOMEN

Ms. CASADY. In preparation for this hearing, about 20 people got together who represent the Sacramento women and AIDS community very well. And they got together to express their concerns and I would like to bring those to you today.

Middle class ignorance allows women to believe that if they are married, have a family and a job that they are above getting AIDS and are immune to the virus.

Women with HIV fear that the medical profession doesn't know what they need because AIDS is a recent disease that has been found mostly in men. There aren't enough doctors who specialize in AIDS, so they don't know women's symptoms and therefore are unable to make an early diagnosis.

Women are excluded from clinical trials because of their reproductive capabilities and they are not being allowed certain medica-

tions that are effective in overcoming the extreme fatigue associated with HIV.

Effects of HIV and AIDS on children range from lack of knowledge about public assistance to death and adoption.

Women have difficulty making arrangements for their children's care after both parents are dead.

Fatigue and other complications such as pneumonia literally put a woman out of commission and make her unable to take care of her child and her family and continue to have a job.

Women are afraid of community rejection. They're afraid that their children will be rejected and poorly treated. One woman was afraid of losing her job, her house, everything. She wanted support from her religious community but even her minister thought it would be best for her not to tell anybody.

I'd like to take a look at several relationships that are involved with women who have HIV or AIDS. One is women and drugs, the other will be women and families and the third is women and health care.

I'd like to describe a woman that we know. Marilyn is 30 years old. She has been using drugs intravenously for about 12 years. She was diagnosed HIV positive a year ago when she was brought to jail because she was picked up for prostitution and possession of illegal substances.

She had been in jail several times and was also in prison because of petty theft. She came to one of the support groups our agency offers to women in jail.

When she was released, she came to the Chemical Dependency Center because she needed bus passes and some clothes—we have a very small client fund—so she could get home—she lives with her mother—and she could see her probation officer.

Her outreach worker referred her to CARES for appropriate case management and made an appointment for her to attend our treatment intake group because she said she really wanted to stop using. She never made it to her intake appointment because she was too busy.

The next time we heard from her, she contacted our outreach program because she was picked up on a probation violation—she had a dirty test. She was given a court hearing date and didn't show up because she overslept.

There are many lifestyle issues that need to be addressed in understanding health care and treatment issues for women drug addicts.

One is living moment to moment and a real complete lack of organization. Lifestyles are chaotic. Excuses such as "I overslept," "I didn't have any transportation" and "I couldn't find anyone to watch my kids" are all valid but reflect an obsession for the use of drugs and an inability to plan and get things together.

Women are sincere about wanting to cleanup and come for their appointments but it does take a certain amount of planning.

Drug addicts are trying to deal with a troubled past and a chaotic present, while avoiding the future. They must deal with difficult survival issues but they are generally alienated from social systems and have a difficult time accessing services.

HIV and AIDS is a disease that people do not want to know about or deal with. It is possible to live with the disease without knowing you have it. If you know you have it, then you feel that you have to deal with it—you have to take responsibility, you have to stop using drugs. You have to have feelings. These are difficult tasks for a drug user.

The next relationship I'd like to look at is women and children.

Women are often diagnosed HIV positive upon delivery of their baby. According to Dr. Hansen at UC Med Center, 50 percent of the mothers who are HIV positive are asymptomatic at the time of delivery and are diagnosed when the baby has symptoms, which may be up to 18 months after birth.

Eighty percent of the children with AIDS are born to mothers who have a history of IV drug use or who are partners of IV drug users. Although 60 percent of the babies born to HIV positive women escape infection, many have been exposed to drugs and are extremely high risk for developmental disabilities.

Women who have used drugs during pregnancy or whose baby was born HIV positive have to care for a child who may have many problems and who needs a great deal of special attention.

Addicted mothers often have feelings of extreme guilt, anger and failure. Like other women, addicted mothers consistently express concern, care and guilt about their role as mothers and the well being of their children. Motherhood may be central to their identity because it is the one job that they can do.

Because of their relationship with drugs, however, motherhood too is a failure. A woman is trapped by a system that makes her feel responsible for the care of her children, even when she is unable to care for herself, and compounds her problem by reinforcing her view of herself as a bad mother if she leaves them to seek help.

The third issue is women and health care access.

Many studies correlate low socioeconomic status, low educational level and poor degree of social integration with receipt of medical care that is inadequate in both quantity and quality.

Poor women's relationship to the health care system has been mainly as passive recipients to medical interventions as dependent patients to dominant providers and having no bargaining power.

Underutilization of medical and health services is affected by financial resources, culture and the health care system itself.

A women must respond to the care of herself and her family using a white male affluent health care delivery system. Sex bias and sex role stereotyping affect the nature, diagnosis and treatment of health problems.

Services are not based on women's diverse individual and cultural needs. For example, early diagnosis of HIV is being overlooked when women experience symptoms that are not yet recognized by CDC as AIDS-defining diagnosis; that is, chronic vaginal yeast infections, cervical abnormalities and PIDs.

Woman's role in society has been defined in terms of her reproductive capabilities. A woman's health needs are overridden by liability concerns and fetal protection.

Women who have HIV or AIDS are denied clinical trials because of these factors.

I'd like to make some general recommendations:

Health care services cannot assume that women are a homogenous group. Appropriate services require data that profile women's diverse needs. Existing and demonstration services must be developed and evaluated to fit particular needs with an emphasis on the impact of social problems.

Integrate and link comprehensive services that include not only the individual woman, but the family, the community and the social system that impacts her.

Improve responsiveness to women's needs by caregivers—health professionals, clergy, police, human service providers. Include training materials that focus on special problems of women, identification of disease, treatment, and appropriate communication.

Include women's services such as rape crisis shelters, battered women services, drug treatment and child care in national health policy.

Educate the public about women's health needs and available services in order to overcome moral judgment and discrimination.

Increase child care and respite care. Child care plays a crucial role in ensuring that women have access to treatment. For example, in one residential drug treatment program, there was a 33 percent increase in utilization by women clients when residential services for both mothers and children were offered. There are similar examples for mental health facilities as well.

And finally, allow community participation in the planning, delivery and evaluation of services including developing community coalitions, employing indigenous personnel and enabling community control. Develop innovative and demonstration programs utilizing in-home paraprofessional health care workers, train community leaders in health care and social problems, establish local community clinics that are accessible and representative of populations to be served.

[The prepared statement of Ms. Casady may be found at end of hearing.]

Mrs. BOXER. Thank you for that overview and for those recommendations.

I understand a Ms. Davis, a woman with AIDS, is here who was going to testify with Dr. Flynn. Why don't you come forward, Ms. Davis, and you can sit next to Ms. Burnett.

Why don't we go to Dr. Flynn now that he is here and Ms. Davis.

Welcome, Ms. Davis.

Mr. FAZIO. I might just say before you start, Dr. Flynn, I'm going to have to leave before this panel is completed. I want you to know that I'm going to take your testimony—and particularly my old friend Patty's—and I'm going to read it and pass it on to my staff in Washington with appropriate responsibility as well as that of the next panel, and I do apologize.

Mrs. BOXER. We're very pleased you took time out to be with us for an hour and a half. It's a big chunk of your day.

So proceed, Dr. Flynn.

STATEMENT OF DR. NEIL FLYNN, DIRECTOR, AIDS AND RELATED DISORDERS CLINIC, UNIVERSITY OF CALIFORNIA, DAVIS

Dr. FLYNN. Thank you, Mrs. Boxer. I am appreciative of the opportunity to testify here today.

I am medical director of two HIV clinics in Sacramento with a combined patient population of around 700 patients. One of them is a university hospital clinic and the other is a private, nonprofit clinic, one of the few in the country, devoted to caring for people with HIV.

Between these two clinics, they provide most of the care for Medi-Cal patients and women with HIV in the Sacramento area, with a population of about 1 million in this area. Seventeen cases of AIDS have occurred in women in Sacramento County and an additional 30 are being followed for HIV infection at the present time.

The problems of women with HIV, as you've heard, are those of all people with HIV but are frequently are accentuated by their status as women and there are a few problems unique to women.

As a medical provider, it is my responsibility to see that appropriate care is received by each person with HIV, whether male or female. We are also responsible for assisting the patient in gaining access to psychosocial care and we are assisted in this responsibility by the other professionals you see here in case management and counselling, drug treatment and social services and so on.

I would like to relate to this committee some of the problems that we encounter now which will become worse in the near future with regard to medical care for which I am responsible.

It is difficult for women with HIV to find an AIDS-knowledgeable medical provider. Most women with HIV must rely on Medicaid, that is, Medi-Cal in California, to pay for their care.

This is because many women with HIV are or have been IV drug users or when they become ill and lose their jobs, they have to rely on Medi-Cal because they have nothing to fall back on.

Over 60 percent of women with HIV must rely on public funding of their medical care from the beginning. A woman with Medi-Cal has great difficulty in finding a medical provider. It's nearly impossible except for in this community, the two clinics that I mentioned.

The only places she can go are University AIDS clinic and CARES. However, as the number of Medi-Cal with HIV increases, these two sources of care may be unable to continue to provide care and so women will be among the first affected.

They are going to be unable to continue to provide care because of Medi-Cal, that is, Medicaid, reimbursement. For example, for every $1 that the clinics charge for outpatient care at UCD, we are reimbursed 33 cents by Medi-Cal and at CARES, the private nonprofit which has no other source of income to fall back on, we're reimbursed at 42 cents on the dollar.

Overhead at CARES, including salaries of the medical people, the psychosocial assistants and the educational personnel is at least 90 cents. Therefore, we lose 38 cents on every dollar that we charge and we have to make it up in some way.

We try to make up the difference from fundraising, private pay and private insurance billings, et cetera. With a load of nearly 60 percent Medi-Cal patients in each of the clinics, this has proven nearly impossible to do and we may go under as a private nonprofit.

There is a real and present danger that these two sources of care will have to limit their care to patients with Medi-Cal, that is, women. These patients will then have no place to go unless to county clinics which are already overburdened.

The prospect is that their care is going to fall below even minimum standards unless Medi-Cal reimbursement is significantly increased.

To compound the problem of finding a medical providers for a woman with HIV in Medi-Cal, the care of that person is very difficult. It's time consuming. It requires a lot of commitment on the part of the primary physician, for which he or she is being reimbursed at a very low rate. So people with Medi-Cal, that is, women, will not be able to find a physician.

The second problem I see arising is a shift of care from current sources to county-run clinics which are already overburdened and underfunded and understaffed. The reason for this shift is that we are now capable of preventing serious illness in people with HIV for several years using AZT and other medications with which we can prevent opportunistic infections.

While this is good news for persons with HIV, it may delay them from getting Medi-Cal public assistance, which is usually available only when they become disabled by illness or develop full-blown AIDS.

Until then, people who rely on public funding for their medical care will receive it from county clinics.

Women with HIV are more likely to fall in this category for reasons that we have talked about here today and the county clinics are not prepared for that shift.

My final point this morning is that there is insufficient emphasis on prevention of HIV infection among women and prevention of disease once the woman is infected, that is, finding that the woman is infected and getting her into treatment.

There are insufficient drug treatment facilities for such women. Sacramento is fortunate in having gotten a Federal grant for prevention among IV drug users, a fairly large one and through that and through other community programs, we have been able to educate the majority of drug users but in many communities, this is not the case.

Multipartnered heterosexual women are three to five times more likely to acquire HIV than are multipartnered heterosexual men and therefore women must be targeted, at least heterosexual women, must be targeted in preference to heterosexual men if we are to make sufficient use of our resources.

Sexually active women must receive more education than ever on HIV avoidance.

In summary, as a physician providing care to women with HIV, I see for them an increasing inability to find expert medical care if they must rely on publicly funded medical care for two reasons: inadequate reimbursement by Medicaid to even cover outpatient

office overhead and delay in becoming eligible for Medicaid due to advances in early intervention, which delay the onset of illness that might qualify them for Medicaid.

They will have to seek care at county clinics and funding for those clinics is already inadequate. And finally, not enough is being done to protect women from infection with HIV. Thank you.

[The prepared statement of Dr. Flynn may be found at end of hearing.]

Mrs. BOXER. Thank you very much.

And thank you, Mr. Fazio, very much. Ms. Davis, would you like to testify next as a follow up?

STATEMENT OF MS. DAVIS, A WOMAN WITH AIDS

Ms. DAVIS. I think a lot of the things that I have on my sheet have already been previously mentioned by the people testifying but I will go over these.

I am a woman with AIDS. I have written up a statement. I do agree with most everything that was said here, including the urgency that we should recognize women are really at risk for HIV and target this population. I think we are an underidentified minority.

Approximately 10 percent of the cumulative cases of full-blown AIDS have been women. In New York City, AIDS is the leading of cause of death between the ages of 25 and 34 for women. It is now estimated that over 100,000 women are diagnosed with HIV. Worldwide, that is an estimation of around 2 million of 6 million that are infected.

Recognition of women with HIV within the health care system remains poor at best. By classifying women into neat, at risk populations such as sexual partners of IV drug users and sexual partners of bisexual men, what happens to the women who are infected but don't generally fit into these criteria? Many women will not fit into this criteria, into these at risk populations and they remain undiagnosed because of this bias. Also because of sexual bias issues, there is a general denial of the possibility of HIV infection in women just to start with.

A physician cannot identify women at risk solely by these parameters. Also, how can you tell when a woman is at risk for HIV with a 5-minute office visit often given within the health care community? I propose a different criteria has to be used in the diagnosis of HIV among women as follows:

Women experience some manifestations of HIV that are gender specific. Moreover, because the criteria for an AIDS diagnosis was based mainly on men as a model, women don't fit into this criteria of an AIDS diagnosis. As a result of this bias, many women die without an AIDS diagnosis, without treatment and without public assistance. This also includes insurance and all people with AIDS should be entitled to insurance if they have this.

The CDC has to allow for these differences in gender and change its criteria in order to escape the charge of sexual bias.

Some of the symptoms often seen in women with HIV are: respiratory infections, chronic fatigue, yeast infections, both vaginal and

systemic, pelvic inflammatory disease and cervical abnormalities, and also a real complaint is diarrhea.

With those types of things decimating their immune system, you just do not feel well. You cannot work with those kinds of problems.

For instance, many problems with chronic fatigue stem from HIV decimating the immune system. But also that can be an indication of—chronic fatigue can be caused by systemic candidiasis and/or other viral infections going on concomitantly at the same time.

Many times, a physician will misidentify that as just being HIV that is remaining active rather than treating and identifying the problem and the cause with the organism.

If an HIV woman complains of chronic fatigue, don't dismiss it as just an HIV infection starting to replicate, but also look for other causes, like I said, that are gender-specific which I mentioned is yeast infections, PID, and things like this.

What makes this infection different for women?

Women are currently being diagnosed that are from the minority groups within the United States and they are often poor and lack resources with which to fight this disease.

Because women with HIV are primary their caregivers within the family, many women put their own health care issues on hold, often at their own expense, if someone such as her husband or child is also sick with HIV.

Women tend to be more socially isolated and lack positive support systems. Also, many lack basic transportation which puts them more at risk for social isolation within our community. Respite care for them from childcare is nonexistent in our community at this time.

Also, a common health issue among women is pregnancy. Women have been excluded from clinical trials largely because of their reproductive capabilities. Largely because of the thalidomide problem in the 1950's, pharmaceutical companies are reluctant to allow women access to medical treatment. This has to change if women are going to be on an equal basis with men in access to health care.

I will say this, that I also think that the Social Security Administration is definitely biased in their treatment of women.

And, also, if an illness is decimating a family where both people are going to die from HIV, the child or survivors of that union are going to be left with only one person's income. This is a sexual bias issue and I strongly disagree with it and women, we ought to vote for our own rights.

That's all I have to say.

[The prepared statement of Ms. Davis may be found at end of hearing.]

Mrs. BOXER. Thank you very much for your strong testimony.

Ms. Burnett, health programs administrator of the Women's Civic Improvement Club. We welcome you.

STATEMENT OF CYNTHIA BURNETT, HEALTH PROGRAMS ADMINISTRATOR, THE WOMEN'S CIVIC IMPROVEMENT CLUB OF SACRAMENTO, INC.

Ms. BURNETT. It seems as if most of the demographical background information that I wanted to present, with regard to women and AIDS, has already been addressed. Why don't I start with just being real specific?

Mrs. BOXER. Good.

Ms. BURNETT. By 1991 AIDS could be the fifth leading cause of death nationally for all women of childbearing age, meaning 15 to 44 years of age.

Approximately 70 percent of AIDS-diagnosed women have IVDU either directly or indirectly as their route of transmission for the virus.

The vast majority are medically indigent and were unaware of their HIV status prior to manifestations of any symptoms from the virus.

Among the women with HIV disease, women of color have been disproportionately infected. The Center for Disease Control gives African American women an AIDS death rate nine times higher than that of white women.

In California, the death ratio is approximately five times greater for African American women compared to white women. AIDS currently is the eighth leading cause of death for all women and the third leading cause of death for black women nationally.

We are looking at a disease that is affecting women, in which the health care delivery system is not prepared to deal with effectively and that is, like most health crises, affecting women of color, particularly black women, disproportionately.

Again, the obstacles to care have already been stated very well by Carol and we're looking at transportation, child care, et cetera. Also, the children of women with HIV disease are only able to benefit from the Social Security benefits of one parent.

In addition, medically indigent women do not receive SSI unless they are AIDS diagnosed. AFDC for HIV positive women is much less than SSI payments. That means women with children or dependents are discriminated against unless they meet CDC's definition for an AIDS diagnosis.

Because women have children—and that's already been addressed as well—I would just state that there are very limited services for pregnant HIV positive women.

Most health care providers are still unable to determine HIV disease indicators for women, prescribe drug treatment and offer informed psychological and emotional support relative to the support which is given to other terminally diagnosed patients.

Due to the lack of information and available studies on the use of AZT with pregnant women, many physicians are understandably reluctant to prescribe AZT for pregnant women with HIV disease.

Risk factors for exposure to the virus in utero is estimated to be higher for women who deliver infants with positive drug toxicologies, but little or no coordination or uniformity in follow-up care is provided, in most states, for these high risk infants.

There are a few examples of some programs that are addressing these issues at San Francisco General, the Moore Clinic at Johns Hopkins University in Baltimore, the State University of New York Health Sciences Center in Brooklyn, all of which have focused on AIDS research and patient care specifically for women and women with dependents as well as infected children.

In looking at some of the costs for care—and I'm going to try to keep this real brief because I believe, Patty, you're probably going to address some of this, so I'll try to narrow it down. The early intervention—meaning providing care, medical care in particular, and social support—at the early stages of infection, as a medical model, provides an excellent opportunity to combat the spread of AIDS.

Current epidemiological data clearly depict the new casualties in this war as being the poor, the working poor, women, children and people of color. The very nature of this information demands and adjustment in how we, health care funding agencies, policy makers and providers, define early intervention.

The socioeconomic disparity, cultural barriers and lack of care provider responsiveness, necessitate a more realistic approach to health care for people with HIV disease

AIDS education is desperately in needed in rural, economically disadvantaged and in all communities of color. Unfortunately, the educational efforts must be accompanied by intensive care of already infected individuals who by and large do not have, seek or receive medical attention until the virus has affected them beyond the ability of early intervention programs to be effective.

In essence, we—health educators and providers—must initiate and continue a health education campaign in areas where people are dying daily of AIDS yet where the community denies any vulnerability to the problem and the models for early intervention focus on treatment of individuals who are aware of their HIV status. And that is a primary difference when you look at communities of color and women versus the general white, gay community.

To mandate the separation of direct service provisions from educational grants based on the epidemiological data before us is medically irresponsible and fiscally extravagant. We can't afford to be extravagant. We don't have enough money.

The average cost of care for PWAs from AIDS diagnosis to death is approximately $50,000 to $75,000 for an average length of time of 15 months.

Statistics given by the State University of New York Health Science Center of Brooklyn estimates the annual cost to the taxpayers' funded Medi-Cal/Medicaid system of $18,000 to $42,000 for HIV infected infants.

The Health Care Financing Administration reports that Federal funds pay for 70 percent of the costs for IVDU AIDS patients, 52 percent of these patients indicate Medi-Cal or Medicaid as their only form of payment.

In 1987, the average public hospital lost $600,000 in revenue to the treatment of PWAs. This tremendous financial burden is forcing many inner city hospitals to cut down on the number of AIDS

patients, perhaps compromise their services and possibly turn to bankruptcy.

PWAs with private insurance are finding that their employers are switching to lower cost insurance and prescription drug plans which do not cover AIDS. Without such coverage, AZT, at an annual cost of $3,000 to $7,500 per patient, is prohibitively costly.

The Ryan White Act of 1990, the CARE bill, will not provide much of the inpatient costs incurred by patients on Medi-Cal and Medicaid in public hospitals.

To look at a minimum, what we feel is needed in our community to address the issue women and AIDS is as follows:

1. The virus has become so pervasive in particular communities in this country that all community-based AIDS education and prevention activities necessitate a provision of direct client services, which will include at a minimum guided referral, assistance for receiving HIV antibody testing and psychosocial support.

And again, this is expanding the way that we currently define AIDA early intervention, education and prevention models. We need models that recognize the fact that people of color are by and large not tested and are indeed infected, so that outreach efforts are intergrated in any and all early intervention models.

AIDS education and prevention models have to include at least minimal service delivery that can provide some psychosocial support services in the way of support groups, et cetera and some advocacy and assistance for testing.

2. To serve the broadest segment of the HIV positive population, specifically the poor, working poor and people of color, all health care providers involved in the treatment, support and medical care of women infected with HIV should incorporate advocacy and support for anonymous testing as components of education, prevention and early intervention efforts.

3. Comprehensive medical follow-up for all high risk infants should be implemented.

4. The recognition of an establishment of the broader definition of people at risk for HIV infection by CDC. The definition should include people who are predisposed to contracting the virus via behaviors such as crack use and related sexual exploitation, as well as living in environments where there is a potential for sexual abuse.

An integration of these cofactors should be included in the development and implementation of health services for women.

5. Funding for mental health services for women with HIV disease, their children and infected children.

6. Residential shelter provisions which can accommodate the entire family by allowing the male, female and children to remain together, including in those circumstances where only one parent is infected.

7. Clinical trials should be more accessible to the poor, the working poor, women and children. This means integrating cultural, socioeconomic and gender-sensitive information in the development of research projects and the selection of trial participants.

8. Mandatory continual learning hours on HIV disease patterns and treatment for physicians working in public hospitals.

9. Expanded patient care and clinical research in poor communities. The working poor usually do not seek medical care until they are unable to work. The definition of access to medical care is narrow and policy and funding determinations are not made with poor communities in mind.

Medical care, just like education and prevention efforts, needs to be culturally, economically and geographically accessible. We need specialized neighborhood clinics or the expansion of existing ones for HIV infected patients in poor communities and we need those clinics to provide specialized health care for female clients.

10. And lastly, a realistic allocation of Federal funds for specific research into perinatal HIV transmission, prenatal care of AIDS patients and uniform definitions and protocols for identifying HIV indicators for women.

[The prepared statement of Ms. Burnett may be found at end of hearing.]

Mrs. BOXER. Thank you, Ms. Burnett. Ms. Blomberg.

STATEMENT OF PATTY BLOMBERG, DEPUTY DIRECTOR, SACRAMENTO AIDS FOUNDATION

Ms. BLUMBERG. Thank you very much, Chairwoman Boxer, for holding these hearings. I want to commend you on being the first. If this is truly the first on women and AIDS, I think it's overdue.

I am currently the deputy director of the Sacramento AIDS Foundation and I have just completed the management of a study that was federally funded under the guidelines of a HERSA AIDS planning grant.

We integrated grants from the Sierra Foundation with funding also from Sacramento County, to take a very thorough and intensive look at the Sacramento region for HIV and AIDS issues and because of the input of the Sierra Foundation grant, were able to look at a 32-county rural issue analysis of HIV and AIDS and a complete copy of the document which will be back from the printer the end of this week will be sent to you and to Congressman Fazio.

It has a complete cost analysis section which we think will be very helpful at both the local and the Federal level.

By the end of 1991, the number of women with AIDS is looked at by CDC to account for about 10 percent of the AIDS cases in this country. As of June, women comprised 7 percent of the CDC reported national AIDS cases.

As of June 1990, the Sacramento AIDS Foundation had over 400 clients; 12 percent were women. Of these 44 women, 56 percent are caucasian, 29 percent are black and 11 percent are Hispanic. We find that we do not represent the same trend as women with AIDS on the east coast do.

The majority of the women live in Sacramento County, with the remainder living in the four counties that feed into our area for health care services.

They range in age from under 13 to over 49, with 89 percent being between 20 to 49. Fifteen of these women are HIV positive and 20 are symptomatic and 9 have AIDS.

We have found that IV drug use at 46 percent and heterosexual contact at 26 percent were the primary modes of HIV transmission.

Mrs. BOXER. Say those statistics one more time.

Ms. BLOMBERG. Forty-six percent of the women with HIV that we're currently treating contracted the virus through IV drug use and 26 percent of the women contracted HIV through heterosexual contact.

One woman that attended our gathering last Thursday found out she was potentially infected with the HIV—and does have AIDS—the day her husband died of AIDS and this was the first that she became aware of his status as well as her potential status for HIV. So heterosexual contact is a large factor in our community.

Mrs. BOXER. Just one question. In the 46 percent that got the disease through HIV, is that their own HIV use? Is that what you mean by that?

Ms. BLOMBERG. Their own IV drug use, you mean?

Mrs. BOXER. Yes; I meant IV drug use.

Ms. BLOMBERG. Their own and their partners. It is primarily divided——

Mrs. BOXER. Their own and their partners.

Ms. BLOMBERG. Their partners.

Mrs. BOXER. And the other number is through other——

Ms. BLOMBERG. Is heterosexual transmission.

Mrs. BOXER. Without drugs involved.

Ms. BLOMBERG. Without knowledge of drugs involved. Taking a sex history by a primary care provider is indeed a tricky situation at best and finding out where the individual got the HIV is not always confirmed by the person knowing the full extent of their partners. So to the best of our knowledge, on self-report, that's the data that we've got.

We found that primary HIV and AIDS health access issues include a lot of those that have been previously testified to. We are concerned with some primary characteristics of women in the Sacramento area that include the majority of those HIV infected being women that are head of household. We do also see a disproportionate number of women who are ethnic background and women of color.

We find that women wait longer to seek services and treatment and that can be due to their low income status. Most lack social or family support systems.

Many women will delay professional help because of the fear of separation from children or that children will be split up into foster care homes.

Women clients have intense case management needs and require a high degree of involvement by multiple social and health service agencies. Most of them lack transportation and many of our agencies do provide transportation vouchers, but even that's not enough. And we have anecdotal information about the information about the horrors of trying to access health care on a bus route.

We've recently applied for a grant with the Pediatric AIDS Foundation in LA with UCD to include taxi vouchers for those women who are so ill and have to take their children to health care treatment with them.

Most of these women that we've worked with come from dysfunctional families, whether it's drug abuse or physical abuse. This does tend to impair their problem solving ability.

Many women have a general mistrust of the health and social service systems because of previous discrimination and prejudice.

Many of these women lack the personal skills to access health care and there's a strong denial of HIV infection or the possibility of HIV infection.

Our contact in the case management system that we have set up shows that almost one social work contact per day is needed for the first 2 months of case management services of the women that we have worked with.

Of these women studied, each required an average of at least 10 referrals to those agencies that are listed in my testimony to you. That includes the WIC program, AFDC, food stamps, housing programs, legal assistance, Social Security, Medi-Cal; not to forget funeral services and planning.

Volunteer support services are a critical part of our care to people with AIDS. And we find that—we just started a women's support group, they are starting to be able to access the volunteer programs even more so.

We find that seroprevalence data on HIV infection in women is important for a number of reasons. Mainly, given the long incubation period, the current number of women may not accurately represent the future epidemic trend.

We're very concerned about another finding in our HIV 2000 study and that is the large number of individuals with AIDS, men and women, in the 20 to 29 year age category.

And when you talk about this long incubation period, that number of individuals obviously were infected during adolescence and yet there is a reluctance on the part of most school districts to adequately address AIDS transmission information to the adolescent population, which even CDC is now starting to recognize is the most vulnerable population in our country with respect to this infectious disease.

We find—to conclude—that the HIV infection for women is primarily different due to problems with medical diagnosis and health care areas that really are specific to women, the first being respiratory infection and illness.

A large number of women in New York studies have died of upper respiratory infections and not until autopsy were found to be HIV positive and pneumocystis was never explored as a possibility for the prolonged cause of their respiratory illness by their primary health care providers.

Gynecological infections—women are at a higher risk than men contracting candidiasis or the thrush infection and yet this is the most—and vaginal inspection could be a common low cost way of screening for thrush and other chronic pelvic inflammatory conditions that women present with to be an early precursor for possible risk of HIV infection.

We find that women that are drug users have an increased number of sexually transmitted diseases, chronic pelvic infection and other diseases that are obviously associated to a combined use of their HIV status and their drug use that needs to be addressed.

And the most controversial issue is women who are HIV infected and planning pregnancy, already pregnant or seeking birth control or abortion. There is evidence in a large amount of the literature

that women who know—that a pregnant woman who knows she's HIV will seldom alter her decision to have the baby. The evidence is that she'll not only continue to have that baby, but like the woman that we've been tracking through multiple service agencies here in Sacramento, is 29 years old, has AIDS, has had three children. The first child has died of AIDS, the second child was born at the Med Center, was identified through the positive drug tox screen and the HIV test done at birth on the prenatal cord blood of the mom, to be HIV and placed in foster care.

That mother subsequently never returned back for her visits to the Med Center, delivered her third child at yet another hospital in our community that did not do routine HIV testing.

Because of the coordination between some pediatric social service providers in our area, that baby was tested. That baby had been placed in foster care because of the positive drug tox screen and was found to be HIV positive and is currently 16 months old and being treated for pneumocystis and is very ill, compared to the middle child is still alive and the first child who is dead.

These present some very critical problems that we want to address to you. Thank you for hearing us.

[The prepared statement of Ms. Blomberg may be found at end ofmhearing.]

Mrs. BOXER. From what you have said to me so far, the feeling I have is that there are more women out there who, for various reasons, don't want to get tested.

Ms. BLOMBERG. That's right.

Mrs. BOXER. Or feel that they'd just rather not know. And so would you all agree that there's probably an undercount of women who are HIV positive?

Ms. BLOMBERG. Yes.

Ms. BURNETT. Yes.

Mrs. BOXER. And therefore, as a result of that, they're not—because we don't know they're positive, they don't get the early intervention.

You wanted to add something to that.

Dr. FLYNN. Yes; I'd just like to emphasize that it's even worse than men. In men, it's probably 50 percent have been tested who are positive. With women, it's probably much less—25 or 30 percent of the positives have been tested and know they're positive. So we need a push for testing.

Mrs. BOXER. So you're saying that if we look at the numbers at the national level, you would guess that there's a big undercount of women who are positive and because most of them—and correct me if I'm wrong; and I've heard everything you say—you're painting a picture that most of the cases come from IV drug use, either their own or a partner's IV drug use.

And because of that lifestyle, it's very difficult to get a woman into a screening program, a treatment program; it's hard to reach her children——

Ms. BLOMBERG. I need to emphasize that in our area, 50 percent is from IV drug use that we know and 50 percent is not. So heterosexual contact is one area that we're looking at that is definitely an indicator of HIV infection.

Mrs. BOXER. And do you feel that the drug user, 50 percent aside, that the remaining 50 percent, that those women are getting screened and getting tested?

Ms. BLOMBERG. No, they're not.

Mrs. BOXER. Or that they don't realize the danger they're in, the potential danger that they're in? So it seems to me that what we have to come back to is what the gay community started off at, which is AIDS is preventable. And so it seems to me the toughest group to reach is the IV drug users.

The next toughest may be the people who get the infection through an IV drug user partner, because that obviously can't be that stable a type of relationship in most cases, so that it's hard to expect certain behavior patterns. But the one area where it might be possible, it seems to me—and I'm going by Ms. Casady's comments that were very strong on this point—we can't underestimate the lifestyle differences of someone who's involved in drug use.

But if we agree that's 50 percent and we put that aside for special attention, that the other 50 percent would be a group that we need to reach, just as the gay community reached its community and said, 'Women, wake up. You may not think that you are in danger, but you're in danger.'

And so it seems to me what we need to do is to have some very clear advertising campaign for starters, an outreach campaign to women, starting at young ages in the high schools and on up to make the case that this panel is making, that women are dying and to take Ms. Burnett's statistics, which were shocking to me, but I want to repeat them to see if I've learned them, which is that AIDS is now the eighth leading cause of death among women nationwide and fifth here in Sacramento. Is that correct?

Ms. BURNETT. Women, black women are dying five times—at a rate five times higher than white women in Sacramento.

Mrs. BOXER. Well, that's yet another statistic. I think you said that it's the eighth leading cause of death in the United States and the fifth among women, and the fifth leading cause of death in Sacramento. But you can peruse your statistics. I'm pretty sure that's what you said.

So we need to wake up the women of America, is what we need to do. And to understand the special problems, including outreach to the kids.

One of the things that we did do this year is have a pediatric AIDS component and I did do hearings on pediatric AIDS. And we did get a component of outreach to women and their babies, so things should break open a little bit for you on these new kinds of grants that you should see coming down because obviously the picture you've painted and Ms. Davis has painted, the inability to get the transit, to get to someplace to get the help if you have to care for your child, you care about your child but you don't have the strength to take the child and go with the child somewhere—that we need in-home kind of outreach and service to families who have multiple cases of AIDS.

So through the pediatric AIDS program, I think that you may find that that reaches out to the women because in all of these pediatric cases, the mother has AIDS.

Ms. BLOMBERG. That takes us back to costs. On the pediatric AIDS, we've been following very closely the Ryan White Act and are advising our California State Office of AIDS on implementation of that and how much money will there be available in the pediatric subsection of that legislation.

Mrs. BOXER. Well, we put a good number in the budget and the question is what the appropriations committee did. That's why I think it's really time to sit down and go over this final budget. We didn't do all we wanted to do because of the Administration's opposition. And that's as clearly put as I can do it, as I can say it.

But we did get $250 million into the Ryan White funding, but we really pushed the children with AIDS program, and for that, it's not always a question of money, either. It's a question of a new type of service delivery and a stress on different reimbursements where we wouldn't reimburse before.

So I hope you'll sit down and go over these budgets because maybe you're going to find some good news in there tucked among the bad in terms of what we've been able to do for AIDS and how it may impact on children.

I'll tell you what I want to do next year, after hearing you—I chair this panel until December 31 and then I don't chair it, but the new chair is going to be—is very concerned about this issue and what I'm going to do is to make sure that just as we've done children with AIDS in the budget and we've called attention to it, that the Budget Committee focus on women with AIDS and starts some special projects that we can flag for the appropriators because once the budget leaves my desk, it goes to the appropriators and then they look at different sections.

So I want to thank you very, very much. Particularly, I want to thank Ms. Davis for coming here because it means a lot to us that you were here. We look at you and we know we need to do more. So that's as simple as it is.

So I want to thank you all for being here and we'll be in touch with you in the future.

I would ask the next panel to come forward. The next panel will focus in on children. Just as the chair of the board of supervisors opened up his testimony stressing children, I think it's a good way to finish our discussion this morning.

Dr. Gil Simon, physician; Dr. Bette Hinton, Sacramento County Health Officer; Ms. Mary Irwin, Community Service Planning counsel. We welcome you.

STATEMENT OF DR. GIL SIMON, SACRAMENTO CHILDREN'S MEDICAL CLINIC

Dr. SIMON. I am a private sector pediatrician, a primary care—what used to be called a doctor. Two years ago I decided that I was going to develop a private practice that would specifically cater to the needs of children in poverty. In my few minutes, I'm going to describe the program that evolved and list some of the barriers that I observed and offer some suggestions.

The Sacramento Children's Medical Clinic was begun January 1, 1989, in order to provide quality specialty care to medically underserved economically disadvantaged children. We quickly recognized

that the neediest families were those who were least likely to have reliable transportation and that our being available to them was meaningless if they had no access to our facility.

We decided to bring our office to them by developing a series of outreach programs. If no space is available in the outreach site, we bring our mobile medical unit, the Clinic On Wheels, a converted family recreational vehicle.

In October 1990, our clinic on wheels visited 20 different sites in Sacramento and wWest Sacramento and performed 328 examinations. Other mobile models that we developed include the use of multiple stations when more than 50 children have been examined. And this was the model we used in performing examinations in our migrant worker camps, which we did last summer.

For less than 10 examinations, we use our MASH unit, which in this case means Mobile Assessment of School Health.

In all situations, as a privately owned and a privately operated practice, we bring our own materials, our own equipment, our own staff. Being a pediatric practice, we see only infants, children, and teenagers. Since our goal is to reach the underserved, we are not interested in seeing children who are already established with a doctor. We come to each site as often as needed.

We come equipped to do the complete health care examination as required by the State Child Health and Disability programs. In the mobile unit, we are also prepared to treat and diagnosis roughly 90 percent of illnesses. For example, we do the rapid streptococcal screening testing in our Clinic on Wheels.

We accept Medi-Cal or the Children's Health Disability Program, CHDP, as payment in full. We receive no grants and are in no way connected to any governmental agency. Ninety percent of our revenue is received by the state programs.

Once a child has been seen, he becomes a Sacramento Children's Medical Clinic patient and his chart is kept in our active files in one of our offices. If the parent's wish an appointment at one of our other offices, they need only call us at either office. Both offices are situated in inner city, low income communities. Of course, if they have no transportation at all, they can continue to have all their visits in the mobile van.

To address the cultural barriers assets, we developed a multilingual support staff and a network of interpreters. We are also experimenting with different scheduling techniques designed to accommodate the very special needs, life styles, attitudes and habits of the long-term poor.

We have formed a subsidiary organization, the California Children's Medical Clinic, in an attempt to replicate our Sacramento programs in other parts of California. An office in Santa Rosa, administers the mobile outreach program in Napa, Sonoma and Marin Counties. Lake County had no need for our services.

In addition, we are awaiting approval of our application for a tax-exempt status for our corporation access roll and its objective will be to raise funds to support research for the development of innovative techniques for the improvement of access to health care.

Our clinic will perform 18,000 examinations in 1990. And I'm told that makes us the biggest provider in Sacramento, including the Medical Center.

In a brief period, we have substantially changed the health status of children in several communities in Sacramento and we plan to expand our program to other medically underserved areas in the coming years.

In this regard, earlier Grantland Johnson mentioned that his community of Del Paso Heights was notoriously deficient in its health services and it's true that prior to 1989, the percentage of immunized children in their pre- school program was less than 20 percent, which is much lower than the State average. As of now, there it is 100 percent.

In October 1990, our Clinic on Wheels visited 20 different sites in Sacramento. And of interest is the fact that in seven of these, or 35 percent, less than half of the scheduled children kept appointments, showing that lack of transportation is not the only barrier to health care.

This brings us to a discussion of barriers to full participation. First, inaccessible care. Of the causes of accessible care, certainly lack of transportation ranks at the top. Many of our patients either have no cars or have cars that won't start or won't get them the whole way to the office.

There are 57 languages spoken in the Sacramento area and very few of us can speak all of those languages. There are other cultural barriers besides languages. In public clinics where a third of all California children receive their care and where I think half will be receiving their care by the end of this century, there is great fear especially among the Hispanic community of going there and being discovered and then being deported. There are a long waits at public clinics and the hours are irregular and infrequent.

The other barrier that we encountered after we thought we had successfully dealt with the transportation barrier is the one that we are having great difficulty with and that is the cultural disengagement of the long-term poor.

To explain this, this is described at the inability or unwillingness to utilize the institutions of the dominant society. Examples in this situation are not attending prenatal clinics, not applying for WIC, not seeking immunizations or routine medical care for their children, even when readily available.

We've had the startling experience of seeing mothers walk into our mobile medical unit with their children in arms showing us their immunization records blank, not a shot being given as a child and then leaving, not staying for the immunization.

So even when available, the chronically poor, the long-term poor are disengaged and do not avail themselves of opportunities even when presented to them. And this is disengagement is believed by some medical anthropologists to be the single most important characteristic of the cultural poverty.

And last, insufficient funding of existing programs. And we've heard this all day long. I believe that the current level that we have to fund the State programs is marginal for the 20 percent who are participating. If the objective is total participation—which it should be—then how are we going to afford an additional influx of all these children?

We were very surprised in approaching the North Bay counties with our mobile program to learn that most of them had very little

use for us and some actually had no use for us. And the reason they claimed was they felt they were doing all they could do, given their budgetary restraints. And that they recognized that 20 percent, 16 percent, 18 percent wasn't very much, but given the circumstances, that's the best they could do. And we have been either denied access or severely restricted in our access to these counties.

Mrs. BOXER. In other words, because they're afraid that it would cost them money, they say Thanks a lot, but we just can't financially do any more, we can't see any more payments leaving the county. Is that what you're saying?

Dr. SIMON. "We can't afford it."

Mrs. BOXER. Because if you will go in there and you pull people out, new people get them into the system, it's going to cost the county even more.

Dr. SIMON. Yes. The county is maxed out. Not every county is as affluent as Sacramento County is, apparently.

Mrs. BOXER. I understand.

Dr. SIMON. And some feel that they absolutely no ability to absorb any additional costs. And if we bring the remaining 80 percent of the children who are not in the program in and we've already reached the maximum ability to support 20 percent, then this would be an unbearable cost.

Mrs. BOXER. I understand.

Dr. SIMON. The recommendations—one, outreach that relies heavily on mobility. We have to go to them. They don't come to us in the great number of cases. Mobility will eliminate the transportation barrier.

Furthermore, we learned unexpectedly that going to the, going to their turf, is a great barrier lowerer in eliminating this cultural disengagement. There is nothing as pleasant as making a house call and making a neighborhood call is even more pleasant. We find that we make friends and we link them into our system and we engage them into a medical system that they're currently not engaged in. So, mobility is No. 1.

No. 2, money. We must provide funds for full participation. We're basically talking about immunizing children and preventing preventable diseases. We shouldn't have one child in California with measles. There is no acceptable that we can endure—zero is the number we should be aiming for.

Mrs. BOXER. And how many died this year?

Dr. SIMON. We had about 40 deaths in California and there shouldn't have been one. And three—these are my three Ms here——

Mrs. BOXER. And I might say that I learned something shocking again in my San Diego hearing, that one of the children who died of measles—and I'm going to say this—and it was corroborated by several people—cost the county $800,000 because the child was so sick and they were doing everything they could. It cost the county $800,000. Now, how many immunizations could you have done for that?

Dr. SIMON. Quite a few.

Mrs. BOXER. My God. Probably the whole State.

Dr. SIMON. It's been learned that just the measles immunization program alone saved $20 billion in health care.

Mrs. BOXER. $20 billion? Say that again.

Dr. SIMON. I'm sorry—that's an error. In the 20 years following the measles immunization program, $5.1 billion has been saved.

Mrs. BOXER. So the nationwide program. And I know the polio vaccine is into the probably $60 billion range. So it's mind boggling.

Dr. SIMON. Yes. The DPT program we know currently saves between $6 and $7 per dollar spent. So these are very cost effective programs and unless somebody goes out to these isolated communities and immunizes those children, we're going to have to endure the cost of cure rather than the smaller cost of prevention.

In that regard, I would also like to say that the ratio of an ounce to a pound has changed during the past few years. An ounce of prevention costs much more than a pound of cure, nowadays.

And finally, my recommendation is motivation. We need to motivate the public sector and the private sector. Having a public health sector that accepts such pitifully low levels of participation must not be tolerated.

We must provide levels of care, we must say that unless you reach these levels, you will be replaced by somebody who can reach these levels and those who do reach those levels should be rewarded with additional benefits.

But without providing some required level of participation, it's meaningless to establish a program that tolerates one child in five who's eligible of being involved in the program.

We also need to motivate the private sector. This can be done start-up grants, with no interest loans, by providing support for the non-reimbursable costs that are borne by the private sector that normally belong to the public sector. And to give you an example of this, we have over 10,000 children now in our clinics and we don't have a social worker. Public clinics with far fewer children have a staff of social workers to take care of their problems. I would love to have a social worker.

This is a nonreimbursable cost for me and I cannot endure the nonreimbursable cost at the level of reimbursement that Medi-Cal provides.

We would be greatly benefitted if we were allowed to participate in the purchasing power of public agencies. During the measles epidemic that we had, the measles vaccine became very unavailable and for me to buy measles vaccine at $34 per dose and be reimbursed by the State at $26 per dose was a very costly proposition; whereas if I had been allowed to participate in the State purchasing power and buying at State rates, then I would have been able to afford far more and get out many more immunizations to these children who needed that so badly.

So we are asked to pay top dollar and we are reimbursed at bottom dollar. And in many cases, at a loss. And this does not benefit the children of our state.

Finally, it would be of great benefit if the private sector were offer favored status during the periods of budget impasse. During the times when the state is not paying its bills to its providers, we must resort to borrowing money or tightening our belts as tight as we can make them.

During this last budgetary crisis, we almost went under. If we had some ability to receive early payments, this would have prevented the crisis that almost ended our clinic.

In short, it's been an incredible venture, one that's been very satisfying and very gratifying and I wish that we could have more support so this can be replicated in other parts of the State.

[The prepared statement of Dr. Simon may be found at end of hearing.]

Mrs. BOXER. Thank you. I'm just fascinated by your testimony and I'm going to ask you some questions after our panel is finished. Thank you so much for that.

Dr. Hinton, Sacramento County Health Officer. Thank you for coming today.

STATEMENT OF DR. BETTE HINTON, SACRAMENTO COUNTY HEALTH OFFICER

Dr. HINTON. As a county health officer in an area of 1 million people, I appreciate your willingness to listen to us and attempt to help us to provide solutions to an evergrowing need for health care for the children of Sacramento County.

Although we live in a county with a rapidly growing population and therefore a rapidly expanding budget, State and Federal funding cuts, an expanding medically needy population and a lack of understanding of the value of preventive care have left us with worsening health indices and no apparent relief in sight.

I would like to speak to you briefly of the gaps in the services to children from conception to the age of majority.

An infant conceived in Sacramento County is increasingly likely to be conceived to a mother who is either unmarried, a teenager, poor, drug using, non-English speaking, or a combination of the above.

If, as is the case for 41 percent of our pregnancies, and 72 percent of our teenage pregnancies, the mother is eligible for Medi-Cal, she faces increasing difficulty in finding care, since the number of obstetricians who are practicing is decreasing, as is the number who will accept new Medi-Cal patients.

We need help to both adequately fund and decrease the bureaucracy of the Medi-Cal system and to encourage physicians to practice in this field.

If the aforementioned mother is accepted into care and willing to participate, there is very little support for her in the community. She will likely have difficulty with transportation, health care will be located outside her neighborhood, and will not be culturally sensitive and the public health system will offer her almost no assistance. Except for one small project, public health field nurses are not available. If she needs extensive assistance, only two small community-based organizations funded by private foundations can offer to help.

In one of our hospitals, there is a 20 percent likelihood that she will deliver her baby with no prenatal care. If she is eligible for WIC, there is only a 20 percent chance that she will be served and no chance of service to her child after the age of 1. The odds that

her baby will die before the first birthday have been increasing since 1986, especially if she is black.

We need financial help and renewed interested in prevention to see that this doesn't continue to happen.

WIC must be adequately funded and we must begin to rebuild our public health infrastructure which has been severely damaged by the emphasis on acute care.

A child born in a hospital in Sacramento to such a mother is generally accepted into pediatric care. In this area, we have acceptable access, particularly if she's born in a private hospital.

However, if the child comes to Sacramento after the time of birth, access to care if he is poor or Medi-Cal eligible is much more difficult. We do not have the public health resources to provide outreach to these children. Federal funding of immunizations is inadequate. WIC services are unavailable and our children are suffering.

In Sacramento, our neonatal death rate is generally lower than State average. However, our infants die at a higher rate than other Californians from age 1 month through 11 months. We must be lacking adequate services for these children.

Of 140,000 children eligible for CHDP services through Medi-Cal, only 40,000 access them. Only 14 percent of those eligible through the extended CHDP eligibility participate. Only one-third of our children eligible for Denti-Cal are using it, in a community without fluoridated water.

Children under 2 years of age and older children who are new to dental care have an extremely difficult time in finding even emergency care because the Denti-Cal program is so poorly funded and managed.

Vaccine preventable disease outbreaks are on the rise. We are experiencing both measles and pertussis outbreaks. Yet Federal and State funding for any but the most minimal of immunization programs is lacking. In the past two years, we have had death from these diseases which are entirely preventable.

As the child progresses in age through our nonsystem of health care, he becomes less and less likely to find adequate humane services. Medi-Cal is inadequate. Financially strapped counties discourage State responsibility patients and the vocal minority of our citizens are blocking good preventive health care programs.

Attempts to place clinics in schools, fluoridation and immunizations are viewed with suspicion. Sex and AIDS education are discouraged and the cycle begins again with a teenage mother or a 25-year-old AIDS patient who was infected with HIV in the teen years.

The Federal Government must lead the way to return us to common sense prevention and health care for all children, regardless of income. Their public health system needs to be bolstered, their environment protected and their medical needs met, while they are young and growing, so that the next generation of voters can be productive citizens.

Thank you for your for your attention.

Mrs. BOXER. Thank you very, very much. Ms. Irwin.

STATEMENT OF MARY IRWIN, PLANNING AND RESEARCH DIRECTOR, COMMUNITY SERVICES PLANNING COUNCIL, INC.

Ms. IRWIN. My remarks were prepared by Nancy Findeisen, who unfortunately was called away from the State on a family emergency. Ms. Findeisen serves as president of the Sacramento City School Board and also as executive director of the Community Services Planning Council, for which I serve as research and planning director.

We do want to express our appreciation to you and to Congressman Fazio for giving our community an opportunity to speak to you on the critical issue of health care access by holding this hearing in the Sacramento region.

Nancy's remarks address health care access particularly as related to children and their families. The first access issue relates to cultural diversity.

Sacramento is one of the fastest growing regions in the country, but our population is growing not only in numbers but in diversity as well. Today, almost 40 percent of the students in Sacramento County schools are children of color, an increase from about 28 percent in 1977.

Currently, in area schools, about 15,000 students have limited English proficiency. In fact, over 50 different languages are spoken by Sacramento school children.

As both Dr. Simon and Dr. Hinton have mentioned, access to health care for these children and their families requires extensive outreach to new immigrant families and services related to interpretation and translation and staff who are sensitive to, and familiar with, cultural differences.

Federal support for translation services, culturally sensitive public health outreach services, and programs to train racial and ethnic minorities for professional and paraprofessional positions in the heath care field are all key elements in promoting adequate access to health care for the diverse population we have in our region.

The second access concern centers on family planning programs.

Sacramento County teenagers give birth at a higher rate than their counterparts statewide. In 1986, 11.7 percent of all births were to teenagers, compared to 10.9 percent statewide. In some communities within the county, more than one in five births is to a teenage mother.

Federal support for family planning services can prevent unwanted adolescent pregnancies, helping young women to postpone pregnancies until they are able to support and care for a child. More family planning services provided in clinics located in communities with high teen birth rates are needed. Federal dollars are needed to fund these clinics which provide services to poor and isolated populations.

The third issue has to do with location of services.

Childhood immunizations provide the foundation for community preventive health care. The percentage of children who have not been fully immunized before entering kindergarten has been declining in recent years.

For example, in 1987 only 7 percent of Sacramento children entering school needed additional shots. In spite of this overall positive picture, in certain areas of our community, many children still enter school with incomplete or no immunization records.

In addition, many of these children have limited access to health care due to poverty and a paucity of health care providers in their neighborhood. I think Dr. Simon has given us some indication of that.

One promising program that addresses this issue is the co-location of health care and social services on school campuses, particularly elementary school sites. This is especially successful if the school is centrally located and is viewed somewhat as a community center by the neighborhood.

One such clinic exists in Sacramento, supported by Cities in Schools, a private nonprofit organization; Health for All, a nonprofit health care provider; and the Sacramento County Health Department. The clinic is located on the campus of Freeport Elementary School in South Sacramento. The Department of Social Services and the City Parks and Community Services Department also provide services on the school site.

On the first day of school this year, 20 students were referred to the Freeport Clinic for immunizations. Had the clinic not been there, the students would have been denied entry into school until they could show proof of immunizations, thereby forcing their absenteeism for one or several days.

Health care professionals and school nurses involved in health screening programs, such as are now provided at the Freeport Clinic, report finding serious, untreated health disorders in young children. In such instances, clinic staff help the family obtain appropriate health care. The clinic's goal is to include the entire family in health care prevention and treatment.

Federal support for clinics like the Freeport model would assist communities in developing quality preventive health care programs. The Freeport school model is an excellent example of this.

The fourth issue is health care insurance.

Over 2,000 physicians serve the Sacramento area. However, not all citizens receive adequate care, due chiefly to the significant number of individuals who do not have insurance coverage. A majority of the new jobs being created in this region are in the service and retail category. Some of these jobs are temporary or part-time and many workers in these jobs have no health care benefits.

A single mother working in an entry-level position or a two-parent family with both parents working for minimum wage both find themselves with incomes below the Federal poverty standard. Twenty-two percent of working people in California do not have health insurance of any kind and ethnic minorities are much more likely to be uninsured.

For those whose income is above the eligibility level for Medi-Cal but who cannot afford the typical $150 or more per month for health insurance, routine health needs tend not to be addressed and the risk of serious illness increases.

Lack of health care insurance is a critical problem for the working poor despite the fact that they are employed. These people have

no recourse but to depend on an underfunded and overextended public health care system.

In summary, the Federal Government can and should provide both policy and financial support for health care initiatives that improve access to quality health care for all people. There are four areas that warrant particular Federal support. These are: (1) translation or interpretation services, culturally sensitive public health outreach activities, and training to enable more ethnic minorities to enter health care professions; (2) family planning services, particularly in high-risk communities; (3) comprehensive health care services provided on or adjacent to schools, especially elementary schools; and, (4) universal health care coverage, especially aimed to helping the working poor.

[The prepared statement of Ms. Findeisen may be found at end of hearing.]

Mrs. BOXER. Thank you for that good testimony. And I hope that you can let our original witness know that we missed her and that we were pleased to have her testimony.

I want to talk, Dr. Simon, to you and then ask Dr. Hinton—maybe I ought to ask Dr. Hinton—do you feel that what Dr. Simon is doing is plugging in some gaps here in this county?

Dr. HINTON. You've caught me off guard because I really wasn't intending to comment on somebody else's testimony.

Mrs. BOXER. Well, you don't have to comment on his testimony, but he's saying that he's reaching out and serving—how many thousands of children did you say in Sacramento—18,000?

Dr. SIMON. We made 18,000 visits this year.

Mrs. BOXER. 18,000 visits to children.

Dr. HINTON. I don't see how that couldn't help—how that could possibly not help. We still have quite a few providers who are saying they cannot find care for children who are Medi-Cal eligible and we know that we're not serving the ones who should be being served on public programs.

I'm sure that Dr. Simon can tell you that any community outreach he needs for his patients is not getting done in general, but it certainly is a help—I mean, 18,000 health care visits are going to do something for the primary care needs of those children.

Mrs. BOXER. So do you think that there is a role for the private sector to play in reaching out to people who are underserved?

Dr. HINTON. Without a doubt. We would certainly, I would think, prefer that over any model if they could do it and not go bankrupt.

Mrs. BOXER. Okay.

Dr. Simon, do you see kids until they're 18?

Dr. SIMON. Yes; or 19 or 20.

Mrs. BOXER. So do you then see kids who are having kids?

Dr. SIMON. Yes; we have a number of visits where we take care of the mother and the child at the same time.

Mrs. BOXER. But you don't do any obstetrics.

Dr. SIMON. We do pregnancy counselling and we do contraception counselling.

Mrs. BOXER. But I mean once the woman is pregnant you have to refer her elsewhere.

Dr. SIMON. Yes; to the other specialists. We're a specialty practice, just pediatrics.

Mrs. BOXER. So I understand—but it seems to me that if you can find a young pregnant teenager and get her in for prenatal care, that would be another very strong point.

Dr. SIMON. Right.

Mrs. BOXER. Do you see a lot of that or not too much? Once she becomes pregnant, would a young girl stay away from a visit with you in a mobile van?

Dr. SIMON. The mobile van's purpose is not to continue to provide care for them in that setting. The major objective of the mobile van is to engage them and to link them and to bring them into one of our offices.

Mrs. BOXER. I see.

Dr. SIMON. So there are a very small number who we see over and over again in the mobile van, but for the most part, they are seen once and then brought into the——

Mrs. BOXER. I see. So you try to get them into a system that can work better.

Dr. SIMON. It's a link.

Mrs. BOXER. Right. You go out, you do the outreach and you hope through this service to get them to become a regular patient at one of your clinics.

Dr. SIMON. Yes.

Mrs. BOXER. Which are located usually in the downtown, inner city areas.

Dr. SIMON. Yes.

Mrs. BOXER. And you don't take any patients with insurance other than Medi-Cal, is that correct?

Dr. SIMON. Oh, no, we do.

Mrs. BOXER. You do.

Dr. SIMON. About 10 percent of our practice is not Medi-Cal.

Mrs. BOXER. So that helps you, I assume, carry some of the losses.

Dr. SIMON. Yes. But surprising, I didn't make any comments on the low reimbursement fee. That's not to me an insurmountable barrier as it is to some other people.

Mrs. BOXER. Well, I want to get to that. I'm trying to figure out what percentage of your practice is private patients. You're saying it's about 10 percent.

Dr. SIMON. Ten percent.

Mrs. BOXER. So the reason I'm kind of excited about your testimony is one of the purposes of these hearings is to identify some models that are working.

It sounds to me that although you nearly went under because of no fault of your own, the breakdown in the State government budget which is something I can't help you with directly but I would hope that for now the crisis is over in that regard, at least until next year.

Dr. SIMON. Until next June.

Mrs. BOXER. Right. I think it really would be fitting to have your assembly person in this district carry some legislation that says emergencies shall be paid. Certainly this is an emergency circumstance.

I'd rather than dwell on that talk about an idea that I'm trying to develop and I haven't got it together yet but I want to give you the outline of it.

And I was struck that whenever you buy a new car you get this book and it says after 1,000 miles bring it in for such and such a check and the mechanic signs off. And it seems to me that if we do that for cars, we ought to do that for kids.

And the thought that I have is that every child that is born, presumably in some hospital somewhere, a child that we somehow can identify, who doesn't have insurance or who isn't on Medi-Cal, should get some type of a well-baby book which is funded by the Federal Government so that—because the health of our kids is our future, so I don't have any—and a kid born in California is worth as much as a kid born in Virginia or anywhere else, so when I look at Federal programs, I think of it in terms of what can we do best.

So if this child's parents or mother gets this well- baby book and it has a certificate in there for immunization, a certificate in there for check-ups at certain ages and the other kinds of things that need to be done for our children, and then they would take that to someone like you or to a county clinic, wherever, and the reimbursement comes for the cost for that.

It seems to me that might be one way we should go because I am taken by your testimony that not one child should have ever died of a lack of a measles vaccine. And putting that together with this testimony in San Diego where they swore under oath practically that it cost $800,000 for this one person, that it would be a cost effective kind of program.

And then I'm taken by your other testimony that goes to motivation, because even if a mother has a well-baby book and she's not motivated to come in, we have to work on that type of outreach as well.

But what do you think about the design—and it could be advertised and talked about—of that type of an approach?

Dr. SIMON. I think it would be wonderful if the mother would not lose the booklet——

Mrs. BOXER. We have to motivate the mother.

Dr. SIMON [continuing]. And would be able to keep it with her each time she comes. Many of our patients are homeless or temporarily homeless and once they get out on the street, within 48 hours most of their possessions are gone. It's very difficult to hold onto these things.

But if they can be encouraged to keep them—an alternative would be some central agency to keep the record on computer—we're in the process of computerizing our entire clinic.

Mrs. BOXER. That might be a way to do it.

Dr. SIMON. And then no matter where they are, we can then bring them up on our screen.

Mrs. BOXER. So there's not a physical book, but there is a—

Dr. SIMON. A record.

Mrs. BOXER. Or there is a physical book and then there's a back-up central listing of children who were born in the county that you could easily ascertain may not be immunized and you can give them that immunization and then send the bill for that to the Federal Government.

It's just something that I think we need to do because the numbers that I'm looking at are just outrageous for a society as sophisticated as ours is.

Dr. SIMON. I don't think you've heard the worst numbers yet.

Mrs. BOXER. What?

Dr. SIMON. While it's true that most of our children entering kindergarten are well immunized, that's not true for the toddlers. We have a terrible gap in toddler immunizations.

Among children attending public clinics in California, this was just published last month in the Journal of Western Medicine, 23 percent of children 7 months of age are up to date with their shots—23 percent. That's half of the percentage of children attending private sector care, which is still a pretty poor, if you ask me.

But this is true up to two years of age and this is being referred to as the toddler gap. So it's true the children are brought up to date in a massive overall of their immunization status just during the seconds prior to entering kindergarten. But during the period of years when they're most vulnerable to these diseases, they're underimmunized. And from 6 months on when they lose their parental immunity to age 2 or 3, they're terribly immunized. It's one of the worst in the world. We're lower than Bangladesh in our immunizations.

Mrs. BOXER. We're one of the worst in the world for toddler immunization?

Dr. SIMON. Yes.

Dr. HINTON. Those, I might add, are the children who did get pertussis this year. It was toddlers across the board. I don't think we had a case of anything else. And most of these kids end up in the hospital for lack of immunization.

Mrs. BOXER. Well, I just have to think about this notion of an immunization right that would go with the child and that people—counties would easily be able to find that child and providers who work with counties so that that child can get taken care of at these early stages.

I remember when Dr. Koop, the Surgeon General talked about the fact that we would never meet our immunization goals—never—we would never meet our prenatal care goals. It's just gone.

If ever there was a missile gap—I mean, it would take us 3½ seconds. And when the Soviets—remember way back—I'm dating myself—launched Sputnik and everyone said, "What? They're better than us?"

Well, we're worse than some third world countries is what I hear you saying in terms of our rate of immunizations or lack thereof in toddlers. So if we get all excited about the missile gap and the space gap, we'd better get nervous about this health care gap.

So I'm going to look at putting something together. I may be calling you to help me put this together so it works. I don't want to just do something that hits and then people say it's not workable.

We've got to do something that works, that's simple, that uses the resources that we have in a real easy way and the payment can be just set until we figure out another way, which is obviously some kind of national health insurance program which is where all this is really leading—to some kind of national health insurance

program so everyone has insurance. Then there's not going to be such a problem.

But right now, what I've heard from the good supervisor here and your testimony indicates that we've got a gap with our children.

I just want to thank you all—do you have anything else you'd like to add?

Dr. HINTON. I would like to say that I hope that the two things that we don't miss are that we really are in desperate need of outreach services and the second is the cultural sensitivity point.

Mrs. BOXER. Yes.

Dr. HINTON. Both to people are foreign born and to American born who are of different colors and of different ethnic types. And we find over and over and over just transplanting a white smart face into the ghetto doesn't make anybody want to come participate in that care.

Mrs. BOXER. Right. Well, I think the classic case of that was—I heard when I went to Fresno, where they had the worst measles outbreak because of the Mung population. And the cultural barrier there was that the religious belief and the cultural belief was that if you invade the skin with a needle, it goes against God's will and there could be all kinds of evil spirits.

And what happened was I think they had the majority of the deaths in that particular county. Totally needless and obviously we couldn't do it with a social worker that came in that didn't understand. So I do hear what you're saying.

We need to approach this crisis in a very different way than we've done in the past, because as you've pointed out and you've said, you've had an example of someone in your office who said, "My baby hasn't been immunized" and then walked out the door, which I don't know how you could even stand that. But it's just—that isn't acceptable.

So we need the outreach, the education in a way that works along with just this notion of giving the right to the shot. You have to also have some education that goes along with it. I understand that.

This has been very, very helpful. I think this whole hearing. We've heard the overview from the elected officials and the people in the county.

We've honed in on women with AIDS and what we need to do there and we've gotten a very good look at the status of children and a very good, I think, option here in the private sector that it can be made to work, even with the terrible reimbursements that we have, which really lead me to say that Medi-Cal is really an illusion of a system.

But I congratulate you on somehow being a good enough manager to make this thing work for you. I think it's extraordinary. You're one of the few doctors that I've seen come forward who said, "Look—I've got a way to make it work." And I congratulate you on that.

Dr. SIMON. Thank you.

Mrs. BOXER. Thank you one and all. This has been a very important hearing.

The Task Force stands adjourned.

PREPARED STATEMENT OF GABRIEL ARCE

Good morning.....

I am Gabriel Arce, CEO of San Ysidro Health Center. I represent one of the largest Community Health Centers in the nation funded by the Public Health Service under the Department of Health and Human Services. Today I want to talk to you about access to care in our part of the world, or the lack of it. Over the years the Federal government has developed a network of community health centers throughout the nation to assure access to care for the low income, the minorities, the poor, the homeless, pregnant women, newborn children, and so forth.

But the need for such a delivery system has far exceeded the Federal government's ability to expand the network of communityhealth centers. In some cases the States have stepped in and funded similar delivery systems. In our case the County has picked up the funding slack, and the community clinics have provided the care. But as the provider of last resort in this State, the counties can no longer cope with the demands for health care any more than they can cope with the demands for other services -- and this leaves too many people without access to care.

Moreover, private providers have been pushed to the limit in terms of offering free or subsidized care, and it is no longer reasonable to expect them to continue meeting the responsibilities on behalf of the cities, counties, states, and the federal government, because government-funded patients form a massive population of less-than-desirable patients based solely on their funding levels and accompanying red tape.

In San Diego a true public/private partnership has been forged between County government and the 22 private, non-profit community clinics. But only three of these clinics receive federal support -- the rest operate on a piecemeal assortment of grants and contracts that continually threaten their stabilityand hinder their growth. Through OBRA 89 the Federal government has created a category of community clinics that are being referred to as Community Health Center "look-alikes". They are organizations that mirror Federally Qualified Health Centers, but do not receive Federal funding. Their mission is to meet access needs so that poor people can get primary care at the very least.

We urge the Federal government to incorporate these "look-alikes" in the funding allocation for Community and Migrant Health Centers in order to insure their survival and guarantee access to primary care -- not only for the 26% of our population without insurance, but also for the 25% who are underinsured. Failure to fund services for this segment of our society jeopardizes the availability of services for everyone when underfunding forces elimination of some specialty services, or, worse yet, the closure of entire facilities or programs -- just as the comprehensive perinatal program for poor women was threatened here in our community only last week.

The counties in California can no longer bear this burden alone; the State is in no financial position to share this burden. It is high time that we acknowledge every person's right to care when they are ill, and the right to those preventive services that will help keep them well and productive. Only the Federal government can address this problem in a concerted manner, and the mechanism is in place to do this -- provide funding for the Community Health Center "look-alikes" through the Public Health Service.

PREPARED STATEMENT OF RICHARD STENNES, M.D.

Members of the Committee on the Budget, I am Richard Stennes, M.D., speaking to you from the perspective of a practicing emergency physician and group administrator in San Diego County for the last nineteen years, as a Past President of the American College of Emergency Physicians and as a former board member of a disproportionate share hospital here in San Diego County.

The Problem for hospitals and physicians, especially disproportionate share providers, is that their ability to provide health care is compromised, as a minimum, and with distressingly increased frequency, eliminated. As a result, access to health care is increasingly restricted, especially for the under and uninsured members of our society. (See Attached Example of a Disproportionate Share Provider).

The genesis of the problem and its affect is multifaceted and complex but includes the following features:

First and principal is the egregiously inadequate payment for services provided to Medicaid and other under and uninsured people. Hospitals and physician's Medicaid payments are so low that private hospitals and physicians' offices cannot stay open if they can't subsidize this cost shifting. Restricted access to physicians' offices means that patients get sicker through lack of care and then go to the emergency department in a more severely ill and costly fashion.

Recently enacted federal and state law mandates that hospital emergency departments must receive everyone without regard for their ability to pay with penalties so severe and relative rewards so minimal as to preclude many physicians from being able to make their services available to provide specialty backup care in the emergency department (see July 11, 1990, attachment to Dr. Richards).

This new federal transfer legislation often seriously further compromises patient health, safety, and finances - - the antithesis of its intent and further compromises the viability of many hospitals, especially disproportionate share private hospitals.

A third major problem relates to the "hassle factor." The paperwork necessary to obtain payment is increasingly complex and cumbersome. The costs of filing this paperwork often exceed the net reimbursement.
A fourth problem is a dramatic increase in the number of elderly sick patients competing for an inadequate number of critical care beds and often must spend a large part of their hospitalization in the emergency department.

A fifth issue is our societal mores and current tort system problems which lead to the expenditure of vast sums to keep

The Congress has largely placed off limit that part of federal spending that was 26% of the budget in 1986 and will be 33% by 1993 - - that is programs for the elderly. When I retire in twenty years, there will be approximately two wage earners for every social security pensioner. Maintaining current benefit levels will likely require at least a 400% Medicare tax increase. Failure to address this issue now will likely result in a much more painful and sudden precipitous drop in benefits at some point in the future. (See Attachment of October 25, 1990, to Senator Bentsen).

The above items deal primarily with price and secondarily with volume. The third issue has to do with costs which will go up in every event.

Fourth, and the most important item to address in the equation, is volume. This requires a re-evaluation of societal mores and changes in the tort system. We must examine the appropriateness of keeping people alive at all cost when they have no hope for recovery or a meaningful existence.

Is it appropriate and do we have the economic ability to keep people alive who have no brain function and exist only by artificial means (Cruzan Case)?

Can we spend $400,000.00 of 'taxpayers' money on an organ transplant when $400,000.00 would buy childhood immunizations and preventive health care for a thousand children resulting in improved health and ultimate decreases in future sick care costs?

The current tort system, which to some degree impacts the above issues, must be re-examined in an effort to try to decrease the need for defensive medicine practices.

We must review and apply the Oregon model developed by Senator Kitzhaber and others in Oregon and apply more rationally our resource utilization in the conduct of health care in this country - - defining what basic and/or adequate health care is.

Whatever is done it can't be built on the premise that emergency departments and emergency physicians be able to continue to be the ultimate safety net unless proper provision is made to pay for the services that emergency physicians are morally and legally obligated to provide.

Provision of services which are unrecompensed coupled with risks of malpractice compounded by onerous federal rules and regulations will ultimately lead to further decreases in access and closure of more emergency departments and trauma facilities.

increasing numbers of essentially dead or near dead people alive for a few more days or hours.

A sixth issue is the development of ambulatory surgery centers, etc., and other ambulatory care sites which treat only funded patients leaving the lesser or non funded and often more complex cases no place to go but to the hospital. HMO type arrangements also take the funded patients away from the non contracted facilities again increasing the ratio of non funded patients that the hospitals must care for.

What are solutions to the problem of declining access and increasing health care costs?

First, an immutable law of economics must be recognized and respected. That is, cost = price x volume.
(quality medical care has a significant cost)

Demand for services will increase if for no other reason than the growth of the population and especially the ratio of elderly (high consumers).

Access to new technologies will be expected and often lead to savings in health care costs by early detection and treatment. They may also result in ever greater costs to the degree that there are more and more people who live longer and consume more care.

Government has chosen to try to control costs by curtailing expenditures. This can only result in decreasing price as volume will increase. However, nursing salaries, etc., costs of equipment and supplies, bricks and mortar and practice expenses are not going down but are increasing. Decreasing payments and increasing costs make it more difficult for disproportionate share hospitals to hire and retain nurses resulting in a 30% turnover per year and an inability to make capital improvements.

Encroachments on physician reimbursement are leading to a decline in physician availability compounded by the problem of the practice of medicine moving uncomfortably closer to the fear end of the fun to fear balance in the practice of medicine.

The solutions will involve several factors:

First, we must strive to more effectively and efficiently apply available resources in the care of patients.

Second, administrative burdens and hassles must be reduced.

Third, will be greater participation by the patients in the cost of their health care. Economic disincentives should not be at a level such as to be a harmful hindrance but must be present to retain interest and restraint.

ATTACHMENTS.

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RICHARD L. STENNES, M.D.
PRESIDENT

(ATTACHMENT 1)

July 11, 1990

James F. Richards, Jr., M.D.
AAOS Delegate to the AMA
American Academy of Orthopaedic Surgeons
222 South Prospect Ave.
Park Ridge, Illinois 60068-4058

Dear Jim:

Pursuant to our conversation during the meeting at the House of Delegates meeting in June of 1990 and upon your request, I have prepared a few comments concerning the problem of Emergency Department Orthopedic Back-Up Specialist Coverage for your review.

The problem of decreasing availability of specialists to provide back-up coverage to the hospital emergency department is a problem of growing severity in many parts of the country and applies not only to orthopedics but many other specialties as well.

Lack of orthopedic back-up is probably the most commonly shared back-up problem in San Diego County Hospitals. Some hospitals have had orthopedic back-up less than half of the month and I am told that many hospitals in San Bernardino County (East of Los Angeles) have none. The reasons for this are, multifaceted and complex but largely social and economic.

First, is the perception, if not reality, of increased malpractice risk associated with patients who are referred from the emergency department to orthopedists. These patients are injured, unhappy, in pain, inconvenienced, and already looking for someone to blame. If they don't think of litigation themselves, they are reminded each morning on television with ads by local attorneys who want to assist them in obtaining retribution for their personal injury. Furthermore, many of them are compromised by substance abuse, acutely or chronically, and often lacking in appreciation and respect.

Second, is lack of funding. State medicaid miserly payment policies, and the percentage of other non-funded patients which is usually in direct proportion to the percentage of medicaid patients, make it economically impossible to care for medicaid patients unless you can transfer the cost to funded patients. The rub comes when --

- One, there are not enough funded patients to do that.
- Two, formally funded patients develop restricted access secondary to membership in IPA, PPO, etc....
- Three, staff physicians don't refer elective cases to specialists on the back-up call panel.
- Four, to an increasing degree, insured patients are operated on in ambulatory surgery centers leaving complicated and non-funded patients in the hospital setting.
- Five, The federal government passes coercive and egregious regulations governing hospitals and back-up specialists.
- Six, hospitals try to mandate back-up coverage as a condition of admitting or consulting privileges.

California Medicaid reimbursement is typically approximately 20 to 40% of charges and difficult to bill and collect for. This rate does not cover expenses let alone leave anything for the "spousal unit". What has to happen when 20, 30, 40 or more percent of the patients are in this category? Add to this the presence of totally non-funded patients whose only source of health care is the emergency department which is by law obligated to receive them.

Compound this problem by the transfer of full indemnity patients to restricted plans. The emergency physician must then send the patient to the plan doctor and/or facility by-passing the on call specialists (except for the major crunch victims). If the back-up doctor does get them it is at a lower rate of reimbursement.

The third item involved reflects the attending staff tendency to refer their elective cases and private patient emergency department cases to a specialist with whom they have an established relationship - - a time honored tradition and practice. Elective cases and private patient emergency department cases tend to be without exception insured and the injury is often a broken hip! Many of the orthopedists who

receive these referrals may no longer be taking emergency department back-up. The orthopedist on call is now subject to only getting unassigned patients which usually means uninsured.

A fourth trend that makes emergency department back up less and less attractive is the development of ambulatory surgery and new techniques that allow surgery formally done in hospitals to be done in an office type setting. These patients are all funded complicating the hospital based problem two fold. First, is the result of increasing the percentage of non-funded patients which can only go to the hospital and second the decreasing need for established specialists to have a hospital practice (and accept back-up call). Sub specialization has also decreased availability of orthopedists available for general care.

A related phenomenon is the development of the Trauma Centers. Formally, when trauma patients went to community hospitals, back up specialists had to be more immediately available to save life and limb. Now that most major trauma goes appropriately to trauma centers, the patient who typically comes to a non trauma center emergency department does not need immediate life saving surgery, at least orthopedically. Thus, the pressure is off and back-up Physicians have come to appreciate that and change their life styles accordingly. Also, specialists have become accustomed to emergency physicians doing complete work ups and treatments prior to admissions and not calling the back-up specialists during moonlight hours unless there is a need for this specialist to come in for immediate care.

Further, the Congress through Cobra and Obra and some states (California) have passed laws that impose a $50,000.00 fine on back-up specialists and loss of Medicare for the hospital for failure to perform properly or if they improperly transfer a patient. This has made emergency department services even more unattractive.

What are hospitals doing to deal with the problem of lack of back-up specialists? There are two approaches that typically apply -- the Carrot (money) and the Stick (mandate).

The medical executive committee in one of the hospitals that I serve voted to mandate that obstetricians take call or lose their privileges. The obstetricians promptly all resigned, closed the OB department and now all babies are delivered in the emergency department by the emergency physician and Gyn back-up has become even more problematic.

The medical executive committee at another hospital with which I am quite familiar mandated that all staff physicians

take back-up call but rescinded the decision within three days as the staff resigned in mass. This is a 210 bed hospital with a few hundred thousand in the service area and the closest hospital being approximately 8 miles away.

The message is that you can't mandate a doctor to do something, for very long at least, that is economically impossible to do. Mandating calls will work, at least temporarily, in those hospitals which are sole providers and/or in which the physician must have privileges in order to produce income.

The comments herein reflect my personal experiences with staffing emergency departments in San Diego over the last eighteen years and my nationwide observation and experience within my specialty society, the American College of Emergency Physicians, and the CMA and the AMA. These opinions should not be construed, through my delegate position to the AMA, as being policy of the American College of Emergency Physicians. I would be happy to discuss these items with you in greater detail at any time.

Sincerely,

Richard L. Stennes, MD, FACEP
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Past President, American College of Emergency Physicians

cc: Robert Anzinger, MD, FACEP
President, American College of Emergency Physicians

RLS/ry

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RICHARD L. STENNES, M.D.
PRESIDENT

(ATTACHMENT 2)

October 25, 1990

Senator Lloyd Bentsen
Chairman, Senate Finance Committee
U.S. Representative Pete Stark
Chairman, House Ways and Means Health Subcommittee
U.S. Representative Henry Waxman
Chairman, House Energy and Commerce Subcommittee
on Health and Environment
Washington, DC 20515

Dear Chairmen:

I have watched with concern the debate over the budget, and in particular for items referable to the Social Security and Medicare entitlements. I am well aware as a 19 year veteran of emergency medicine in a disproportionate share hospital that many of the elderly depend upon what was intended to be "supplemental security income" as their only source of income in retirement. Many, of course, cannot afford to buy a Medigap policy, have Medicaid as their Medigap, or simply are unable or unwillingly to pay co-payments and deductibles. For many of these people Social Security and Medicare is indeed welfare. I submit, however, that the majority of entitlement recipients who receive SSI and Medicare benefits find these benefits to be truly supplementary and would not be significantly adversely affected by limitations on benefits or increased costs for Medicare, at least to a level that approximates the real cost of the services that they receive under Medicare.

What prompted me to write this letter is the enclosed article from Medical Benefits of October 15, 1990, figure 2 which shows the "Population Aged 65 and Over as a Percentage of Population Aged 15 to 64, 1990 and 2030." You will note that the ratio is approximately 19% in 1990 and is projected to be approximately 31% in the year 2030, if not much sooner. There will not be enough money printable nor taxable by the federal government to support the current system under these projections.

Given the current extremely high re-election likelihood of incumbents, one could reasonably expect that a congressman could sustain what might be an unpopular vote in an attempt to correct a problem now that will only get more difficult but more necessary with time.

A significant solution to this problem, in the near or long term, cannot be reductions in the physician component of Medicare costs as there is not enough margin in most physician's practices, especially emergency medicine, to sustain reductions and still maintain access despite federal laws that require us to see all patients without regard to their ability to pay.

The solution to the problem involves at least two features. First is an increase in the financial participation on the part of beneficiaries in their health care costs, at least those who have the ability to pay for it, and a part of that would be limitation on benefits. Recognizing the difficulty of doing this with the current beneficiaries it may be more politically feasible to establish new policies effective with those people who are to become eligible in the future.

An area that needs urgent attention and is currently greatly problematic, certainly from my perspective in emergency medicine, are issues attendant to the patient's right to die. Nursing homes, Emergency Departments and hospital critical care beds are currently filled with many people whose every breath and motion is painful, who have no hope of ever being aware of their surroundings or have no possibility of life beyond hours, days or weeks but are kept alive through the miracles of modern medicine and our current tort system. This issue, and those raised by Senator Kitzhaber in Oregon on the rational application of limited resources, needs the immediate attention of the federal government.

Sincerely,

Richard L. Stennes, M.D.

RLS/wc

Enc

cc: Texas Medical Association
California Medical Association
American Medical Association
American College of Emergency Physicians
John Kitzhaber, M.D., President Oregon State Senate

Medical Benefits

Volume 7, Number 19 October 15, 1990

HEALTH CARE COSTS
Page 1

COST CONTAINMENT
Page 6

[illegible]
Page 8

EMPLOYEE HEALTH
Page 10

Insurers Are in the Money...
Profits are up and competition is down. Times don't get much better than this for health insurers.
Page 3

...And So Are the Docs
In 1989 physicians got their biggest raise in 60 years. Net incomes jumped an average of almost $15,000.
Page 4

Case Mix: A Recipe for Loss?
Some employers are anxious to adjust their hospital payments by severity of illness. Chances are they'll lose on the deal.
Page 5

International Benefits: Health Care

EBRI Issue Brief, September 1990

"In all industrialized countries, employees receive certain noncash benefits in addition to cash compensation for time worked. The level of total compensation varies considerably among countries, as does the proportion of total compensation that is devoted to benefits, which ranges from 22 percent in Canada to 47 percent in France (Figure 1).

It is a well-known fact that the United States spends more on health care than any other nation (Table 1, page 2). The United States is not alone, however, in experiencing rapidly growing health care expenditures. A comparison of the

Continued page 2

Figure 1. Average hourly compensation costs, and benefits as a percentage of total compensation for production workers in manufacturing, 1988.

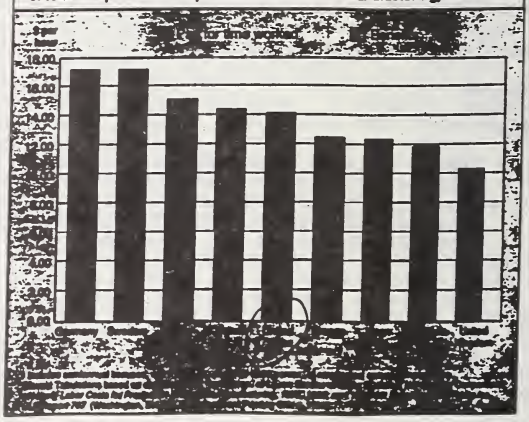


Table 1. Decomposition of growth in national health care expenditures, by country: 1977–1987.

	10-year compound annual growth rate								
	France	U. K.	Australia	Canada	U. S.	Sweden	Japan	Germany	Netherlands
Nominal growth	12.8%	12.3%	12.3%	11.9%	11.4%	10.5%	8.3%	8.9%	5.9%
Inflation	7.1	10.1	8.7	8.5	8.0	9.0	3.5	3.8	3.7
GNP price index	8.5	8.2	8.5	6.4	5.6	8.4	2.2	3.4	3.2
Excess health care inflation	-1.3	1.3	0.2	2.0	2.3	0.5	1.3	0.4	0.5
Real growth	5.4	2.0	3.3	3.2	3.1	1.4	4.6	2.0	1.9
Population growth	0.5	0.1	1.4	1.0	1.0	0.2	0.7	0.1	0.6
Utilization/intensity	4.9	1.9	1.9	2.2	2.1	1.2	3.9	2.0	1.2

Source: Employee Benefit Research Institute tabulations of data from U.S. Department of Health and Human Services, Health Care Financing Administration, *Health Care Financing Review*, 1989 annual supplement (December 1989).

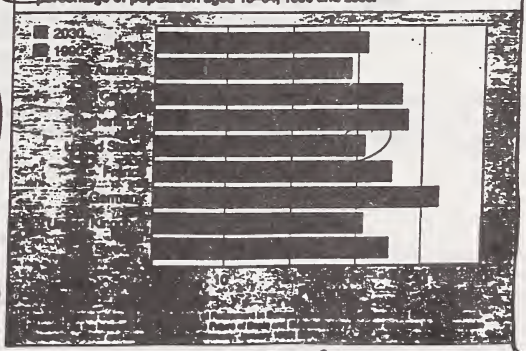
International Benefits (continued from page 1)

growth in health expenditures among the countries under consideration in this discussion reveals that between 1977 and 1987, France, the United Kingdom, Australia, and Canada each averaged higher annual nominal growth in health expenditures than the United States. Increases in nominal growth measures can be attributed to several factors: price inflation (general and health-specific), population growth, and growth in the utilization or intensity of health care services provided. The United States experienced the highest [compound annual] growth due to health care-specific inflation (2.3 percent) during this period, with Canada close behind (2.0 percent).

A comparison of real growth in health care expenditures (that is, growth exclusive of inflation) reveals that France, Japan, Australia, and Canada outgrew the United States from 1977 to 1987. The United Kingdom, whose growth is mainly attributable to general inflation, experienced relatively slow real growth (2.0 percent average annual growth) in national health care expenditures during this period. Controlling for population growth, France and Japan experienced the highest average annual growth in health care expenditures attributable to increases in utilization and intensity during this period (4.9 percent and 3.9 percent, respectively).

The increasing number of elderly persons (Figure 2) directly affects overall health spending. An aging population causes an increase in the intensity of health care services provided, because older people generally require more health care services than younger individuals. Moreover, as the ratio of elderly to working age persons increases, the health care burden on the economy as a whole increases." ■

Figure 2. Old age dependency ratios: population aged 65 and over as a percentage of population aged 15–64, 1990 and 2030.



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RICHARD L. STENNES, M.D.
PRESIDENT

What is a Disproportionate Share Provider?
(Attachment 3)

An analysis of the Paradise Valley Hospital emergency physician professional components for the first nine months of 1990 provides an example and is reflective of the hospital component as well.

68.7% of patients seen are registered as unemployed

38% of patients are Medi-Cal beneficiaries

We collect 23% of charges on this group of patients.

(11.6% of Medi-Cal patients are admitted from the emergency department to the hospital on a nationwide basis)

18% are uninsured and have a 14% collection ratio.

12% are Medicare and have a 43% collection ratio.

(43% of Medicare patients seen in emergency departments nationwide are admitted to the hospital. That is, nearly 1 in 2 Medicare visits result in admission)

7% are medically indigent adults and have a 28% collection rate.

PREPARED STATEMENT OF LISA FIRTH

Madam Chairman and Members of the Committee, thank you for the opportunity to present testimony regarding cost and access to health care for childbearing women and their infants. My name is Lisa Firth, and I am Regional Coordinator for San Diego and Imperial Counties Regional Perinatal System. This program is one of a network of "Regional Perinatal Programs of California" funded by the State Maternal and Child Health Branch to improve pregnancy outcomes by insuring that perinatal health care services are of high quality, accessible, comprehensive and integrated. Prior to coming to the United States in 1985, I worked as an OB/GYN physician for the British National Health Service.

Newborn infants are the most vulnerable members of our society. They are also those with the greatest potential. To invest in their well being is to invest in our own future as individuals and a society. During a time when health care inflation is escalating, and when financial and human resources are limited, it is crucial that this investment be made wisely. My testimony today will focus on two areas where government can play unique and important leadership roles to insure responsible use of the resources devoted to perinatal health care. These are: promoting universal access to prenatal care and developing integrated health care services for childbearing women and their infants.

ACCESS TO PRENATAL CARE

Lack of prenatal care has been clearly linked to poor pregnancy outcomes. Women who fail to receive care arrive at emergency rooms in labor, often with complications that could have been avoided through early, consistent care. Their infants are frequently born too small, too soon and too sick to have a fair chance of a healthy, productive future. Studies have demonstrated that every dollar invested in prenatal care generates a short-term saving of $3 to $4 in initial hospital costs for infants born to mothers without care. When the cost of follow-up care for the child is added, these savings are multiplied. Adding the long-term human and financial costs of an individual whose potential is harmed irrevocably makes the relatively small investment in prenatal care appear even more attractive.

Reasons for the lack of prenatal care are complex, but can be considered from two perspectives: the availability of providers and the willingness of women to seek care. Both are areas where effective governmental leadership can make a huge difference.

Provider Availability

The shortage of affordable, accessible providers is the primary reason for women being unable to obtain adequate prenatal care. There is both an absolute shortage of physicians who accept Medi-Cal and an uneven distribution of these physicians, which makes the shortfall particularly acute in many geographical areas. This can be either because there are no (or few) providers serving low-income women or because the large number of patients overwhelms the available resources.

Although there is still a great deal to be done to solve this problem, several public and private initiatives in this area have prevented our already disastrous "no-care" rates from becoming even worse. First, improved physician reimbursement, expanded eligibility (to women with incomes up to 185% of the federal poverty level) and the introduction of the Comprehensive Perinatal Services Program (providing enhanced services and reimbursement) by Medi-Cal, make provision of services to low income women less financially burdensome to providers. Secondly, streamlining of the application process is helping more pregnant women to apply for and stay on Medi-Cal during their pregnancies. Finally, here in San Diego, a grant to provide a prenatal care "hotline" to screen and refer patients to participating physicians has made our intensive physician recruitment efforts much more effective.

Availability of prenatal care for low-income women could be further enhanced by:

* Use of **Nurse Midwives and Nurse Practitioners.** Effective and affordable perinatal care for low risk women can be provided by certified nurse midwives where they are available and allowed to practice. Nurse practitioners can also provide prenatal care. Incentives are needed to encourage hospitals to develop midwifery services, to encourage physicians to provide back up to these services and to encourage the training of certified nurse midwives and OB nurse practitioners.

* **Development of Innovative Partnerships.** Community clinics are in an excellent position to provide low-cost, comprehensive prenatal care, but frequently cannot obtain agreements from physicians and hospitals to provide delivery services for their patients. Incentives need to be provided to hospitals and physicians to enter into partnerships with community clinics and birthing centers (for low risk deliveries). Sponsorship of newly qualified obstetricians to provide Medi-Cal services in areas of need, possibly within existing private practices, should also be considered.

* **Continued Physician Recruitment and Retention.** Currently, providers are being lost because they cannot make Medi-Cal reimbursement meet their bottom line. Medi-Cal physician reimbursement levels **must** keep pace with costs to avoid the loss of existing providers. Rewards for providers who care for a large volume of publicly-funded pregnant women and assistance with billing would also encourage recruitment and retention. The threat of malpractice suits is sometimes cited by doctors as a reason not to accept Medi-Cal patients; assistance with malpractice coverage or simple education that these patients are not particularly litiginous may overcome this barrier.

* **Increased Reimbursements to Hospitals** for intrapartum services. While physician reimbursement levels have improved, it is becoming increasingly difficult for hospitals to break even on Medi-Cal funded obstetric patients. This is causing concern that, rather than expanding partnerships to care for these women, hospitals may discontinue their Medi-Cal contracts altogether. Legislation is needed to insure that hospital reimbursement keeps pace with costs.

* **Simplified Medi-Cal Billing and Eligibility.** Delays and denials in payment are powerful disincentives to providers accepting Medi-Cal. In addition, having to repeatedly renew Medi-Cal eligibility during pregnancy often causes women to lose coverage. Continuous eligibility for the pregnancy with simplified, prompt payment mechanisms should be minimum standards.

* **Increased Numbers of Bilingual and Bicultural Providers.** Ability to communicate effectively is a prerequisite of quality care, and programs serving low-income women experience difficulty recruiting bilingual staff. Training of new minority health care providers and language/cultural training for existing providers is essential.

* **Provision of Support Services.** An obvious way to improve access to prenatal care in underserved areas is to provide transportation -- either for patients or for providers. Other support services include child care and, where bilingual health professionals are not available, interpreter services.

Patient Education

At present, there are still more low-income women seeking care than there are services available for them. While provider recruitment remains the priority, educating women to seek early prenatal care and to apply for Medi-Cal if they could be eligible are also important. In San Diego we are fortunate to have some new resources for doing this:

* **1-800 675-BABY** -- The Perinatal Access Project. In November 1989 the James Irvine Foundation funded a two year grant proposal, developed by Regional Perinatal System staff, to set up a "hotline" for women seeking prenatal care. The grant is administered by the American College of

Obstetricians and Gynecologists, and local obstetricians, who each accept at least one new Medi-Cal patient per month, have been recruited. Although some areas of the county remain severely underserved, "no-care" rates have risen less steeply than expected since the implementation of this project.

* **Prenatal Care Guidance Program.** Using new tobacco tax monies, the State has funded this County-based program to provide outreach and case management for high risk pregnant women. It has begun work to get women into prenatal care early and keep them in care, as well as helping them to access support services.

* **Information Campaign.** The San Diego/Imperial chapter of the March of Dimes Birth Defects Foundation has provided funding for a multi-agency project, with Regional Perinatal System as the coordinating agency, to educate women on the need for early prenatal care and the availability of Medi-Cal. The first "products" of this project, short videos in English and Spanish explaining the Medi-Cal application process and showing women who relate positive experiences of early care, are being used throughout the county.

Remaining barriers to adequate prenatal care are due largely to fear and/or ignorance on the part of the women who need it most. To overcome these barriers we need:

* **Expanded Outreach Efforts.** While most women realize the importance of prenatal care and endeavor to obtain it, those at highest risk of complications may not know that they are Medi-Cal eligible or how to find a provider. In San Diego, outreach to Spanish-speaking patients is particularly important. Despite recent changes in Medi-Cal regulations granting Medi-Cal eligibility, regardless of immigration status, to women who normally reside in California, those who are here illegally often do not apply for fear of deportation. Their babies, who, if born here, will be U.S. citizens who qualify for Medi-Cal, are subject to the expensive complications associated with lack of care. In addition, it is important for these women to be on Medi-Cal so that the hospitals which deliver them do not have to shoulder an unfair burden of uncompensated care.

* **Expanded Services for Substance Using Women.** San Diego is fortunate to have one of five pilot programs funded by the State to provide treatment and recovery services to substance using pregnant and parenting women. Our "Options for Recovery" program is a fine example of interagency collaboration between County departments and community organizations and provides family-centered care to clients in several different settings. Although this program is a step in the right direction, the majority of substance-using pregnant women remain unreached and without help. Continuation and expansion of such services is essential to stem the tide of drug exposed infants which threatens to overwhelm our educational system. Substance using women are reluctant to seek care for fear that the discovery of their addiction may expose them to prosecution or the risk of their children being taken away. Outreach education concerning the availability of services and the hope of recovery will be effective only if there is no threat of retribution for those who seek help.

* **Accessible, Affordable Family Planning Services.** Lack of family planning services increases the demand for more costly perinatal services and abortions. Also, women with unplanned or unwanted pregnancies are less likely to enter prenatal care early than women who plan their pregnancies. Provision of truly accessible and affordable family planning services has the potential for solving many of the problems faced in providing effective prenatal care.

INTEGRATION OF PERINATAL SERVICES

Both our progress to date and our future ability to address unmet needs regarding access to prenatal care are dependent on cooperative effort and innovative partnerships. For delivery and postnatal care of women and infants integration of services is equally, if not more, important.

Much of the increasing cost of providing health care to childbearing women and

infants results from advances in health care technology. These advances have allowed us to save tiny, sick babies and insure that women with complications of pregnancy are delivered safely. However, most women experience normal pregnancies and deliveries and have no need of "high tech" medical interventions. These women can be delivered safely in "low-tech" settings, such as birthing centers, which are conducive to comfortable, family centered care and less costly than highly equipped tertiary care facilities.

It is equally important that women with pregnancy complications and risk factors have access to those hospitals that have the specialist perinatology and neonatology services appropriate for their needs. Integration of services and strong linkages between providers are needed to allow this to happen consistently and to use these expensive resources appropriately. In a highly competitive and compartmentalized health care industry this cannot be expected to occur spontaneously. The most important function of regional perinatal programs is to act the facilitator for this process. For effective integration of services there are several prerequisites:

* **REGIONAL Coordination.** Most counties are too small to contain the full range of perinatal facilities, while states are often too large to administer integrated services at the local level. Regional coordination based on at least one tertiary care facility is the rational alternative. This enables the expertise of specialist providers to be shared with others in the region and should also prevent the tertiary care center being overwhelmed with patients whose needs could be served better by other community resources.

* **Bridging of Professional and Institutional Barriers.** While the United States generally, and Southern California in particular, is rich in health care resources, the complex issues relating to delivery of effective perinatal services cannot be solved by any one agency or institution. It is, therefore, important to provide for coordination and bring together private, public and non-profit resources in a "neutral" forum where they can work together. Our progress on access to prenatal care here in San Diego through the Regional Perinatal System's "Perinatal Access Alliance" is an excellent example of such cooperative efforts. To be most effective, the coordinating agency needs to be perceived as community-oriented and not vested in either a private or a governmental institution.

* **Strong Governmental Leadership.** Although regional perinatal programs work best when they are autonomous enough to respond to the regions needs, strong government commitment and leadership are needed to support such programs. Legislation is needed which supports not only regional perinatal programs but also the concepts they imply, such as clearly designated tertiary centers and the provision of "low-tech" facilities such as birthing centers. In a largely private health care system, the coordination and integration of existing services is a legitimate and appropriate role for government.

* **Stable Funding.** All publicly-funded programs must be accountable and subject to scrutiny of their functions and services. However, changes in funding of existing programs must be made with great caution to avoid disruption of the services and partnerships which may have taken years to develop. This is particularly true for regional perinatal programs, which are low-cost but sometimes criticized by those who believe that all public health care funds should be spent on programs providing direct clinical services. This belief tends to provide piecemeal solutions, since government cannot, at present, meet all health care needs, and may also cause waste through costly duplication or the funding of services which other agencies could provide.

In conclusion, in these times of fiscal restraint and escalation in health care costs, it is essential that we invest wisely in the future of our youngest citizens. Health care providers are generally willing to work together to solve the problems we face in the provision of perinatal services, but rely on government leadership to assist with coordination and to provide adequate, stable funding for programs that work.

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PREPARED STATEMENT OF JUDY BECK

Thank you for the opportunity to testify on my views of funding needs for children's health care.

I am speaking as a nurse practitioner employed by a large urban school district, responsible for health services for students enrolled in public schools; and also as the project director of a state funded case management program for pregnant and parenting adolescents, including special services for pregnant teens who are substance abusing.

Health needs of students enrolled in public schools today are affected by a number of social as well as health care issues including:

- Age range of children served by education extends from infancy to 22 years.
- Handicapped children, some with significant physical handicaps, require time intensive nursing services to safely attend school.
- Decrease in the numbers of intact family environments has placed increasing responsibility on school districts to solve health and social problems for children - often this must be done as crisis oriented problem solving without benefit of long term solutions.
- There are large numbers of families in our communities who do not have medical insurance and who are not eligible for MediCal coverage.
- Children attend school daily; services for children could be delivered in this setting with the combined effort of school and community personnel.

Educators are well aware of the need for children to be well rested, well nourished, and healthy in order to learn in school. However, public education does not have the resources to solve the many evident children's health and social problems that are identified during the course of each school day.

Traditionally, school health services personnel, namely school nurses, have identified children with health problems, have assisted parents in finding an appropriate source of health care for further diagnosis and treatment, and would monitor that referral to ensure the health problem was remediated.

Currently, there is a large segment of our population which is without insurance and is not eligible for public assistance so the identified health problems are duly noted, but often affordable treatment cannot be found. Children with serious chronic diseases often are not under consistent health management and only receive treatment for acute episodes in an emergency room setting.

My recommendation for addressing the very major gaps in health care for needy children is that interagency services at federal, state, and local levels be initiated to address the health needs of medically underserved children.

Educational systems have as their mission education of children and can effectively work with health and social services agencies to improve the quality of life of needy children. Education cannot solve the health and social problems alone, however these children are seen daily; school is in fact the child's workplace, and programs developed and supported by health and social service agencies can operate very well in school settings where a community service center focus can be established.

PREPARED STATEMENT OF NANCY L. BOWEN, M.D.

During this brief presentation, the health status of children and their unmet health needs will be described.

Children's Health Status

Overall, in the United States most children are healthy but:

a) we are not doing as well as we could
b) addressing health problems in early childhood can benefit a child an entire lifetime and
c) burdens of lack of health care access, illness, disability and death are not borne evenly.

Subpopulations of children that have a disproportionate share of problems include:

i. minority, especially black, children
ii. low income children
iii. homeless
iv. foster care children
v. infants and toddlers
vi. adolescents

Children's Unmet Health Needs

Children's health needs can most effectively be addressed in the context of a comprehensive national strategy that addresses changes in the American family that impact on children's health and their health care access. These changes include increases in:

a) the percentage of mothers who work outside the home
b) the percentage of children in poverty
c) the percentage of chidlren with no or limited health insurance coverage
d) the percentage of single head-of-householders

A comprehensive strategy would include universal health insurance coverage for children.

Specific areas that need to be addressed include:

1) Easily accessible prenatal care services for all women (including teenagers) so that children have a healthy start.

2) Increasing the access to well child visits. Important components of these visits include:

° physical exam and tests that screen for illness and developmental problems
° health education
° parental guidance

3) Promotion of good health habits through the schools, churches, social clubs, medical providers and the media. The health habits should address:

° injury prevention, e.g., seat belts, bicycle helmets, etc.
° physical fitness (cardiorespiratory and muscle tone)
° good nutrition
° healthy ways to reduce stress
° avoidance of self-destructive activities, e.g.,
  a) smoking
  b) drinking
  c) drug abuse
  d) unsafe driving

4) Resolving to solve high risk, teenage sexual activity through:
   a) open discussion
   b) training of health professionals
   c) more effective health education
   d) increased access to family planning

5) Establishment of an adequate system so that "child abuse/neglect families" can be referred into home health visitors, such as Public Health Nurses and further abuse/neglect can be avoided and identified promptly. Home health visitors:
   a) assess the home environment
   b) link parents to support services (such as respite care)
   c) educate parents on constructive parenting techniques and proper expectation of children's behavior

6) Expansion of services for dental health including:
   a) dental care coverage
   b) fluoride
   c) dental sealants
   d) classes on oral hygiene

7) Implementation of agressive infant/toddler/school entry immunization programs

8) Institution of formalized, comprehensive health assessment, referral and follow-up of foster children

9) Establishment of decentralized, intensive and individualized health care programs for homeless children.

Background Health Statistics on Children

Children's Insurance Coverage in the U.S. in 1986

19%	under 18 had no coverage
16%	were covered by Medi-Caid
67.5%	were privately insured

Source: Child Health USA '89, Public Health Service

Newborns Without Health Insurance in 8 Counties of California

	Overall	Latinos	Asians
1982	5.5%	8.2%	7.8%
1986	8.0%	19.7%	12.0%

Source: New England Journal of Medicine, 1989; 321

Percentage of U.S. Women, 18-45 (of child bearing age) Years Without Health Insurance in 1984

Overall	Black	Latino
17%	23%	26%

Source: New England Journal of Medicine, 1989; 321
This points out significant and worsening problems of inadequate health insurance.

Median Family Income By Family Type By Presence and Age of Children: 1980, in San Diego County

	Married Couple Family	Male Householder No Wife Family	Female Householder No Husband Family
With Children Under 6 Yrs.	$18,653	$10,712	$ 5,696
With Children 6-17 Yrs.	27,251	19,957	10,463
Without Own Children	21,803	17,565	14,377

Source: SANDAG
This table demonstrates besides the high rate of poverty among children, the situation is even worse for single female parent households, especially with preschool age children.

Mortality Rates Per 1,000 Live Births By Ethnicity 1987, in San Diego County

	White	Black	Hispanic	Other
Neonate	6.3	10.2	5.4	4.5
Post Neonate	3.6	6.2	2.8	1.7
Infant Mortality	9.9	16.4	8.2	6.2

Source: San Diego County Vital Statistics
This points out the significant rate for infant deaths especially for black children.

The General Fertility Rate, Number of Live Births Per 1,000 Women Aged 15-44 in San Diego County

	1984	1985	1986	1987
General Fertility Rate	73.3	73.2	74.2	76.0

Age - Specific Fertility Rates, Number of Live Births Per 1,000 Women in the Age Group

Age Under 15	0.7	0.7	0.8	0.9
15-19	43.3	44.0	43.3	47.4
20-24	116.0	122.9	126.0	123.2
25-29	121.6	122.0	128.4	137.6
30-34	79.1	76.1	77.9	81.4
35-39	28.7	30.4	30.5	32.9
40-44	5.9	5.4	6.0	6.5
45 and over	0.3	0.3	0.3	0.4

Source: San Diego County Vital Statistics
This points out the particular problem with increasing fertility rates, especially among young teenagers.

Fertility Rates Using 1980 Data

	15-19	15-17	18-19
U.S. total	96	62	144
U.S. white	83	51	129
England and Wales	45	27	75
France	43	19	79
Canada	44	28	68
Sweden	35	20	59
Netherlands	14	7	25

Source: Family Perspective, 1985; 17
This shows the glaring teenage pregnancy problem the United States as compared to other comparable countries even if U.S. "whites only" are compared.

Reasons for high pregnancy rates among U.S. teenagers as compared with 37 other industrialized countries: The authors of an article entitled "Teenage Pregnancy in Developed Countries: Determination and Policy Implications" concluded:

1. Teen pregnancy rates are lower in countries where there is a greater availability of contraceptive services and sex education.

2. More equitable distribution of income is negatively related to the birthrate for girls under 18, i.e., the greater the disparity in income between the "top" 20% and the "bottom" 20%, the greater the teenage pregnancy rate.

3. There was no correlation found for:
   amount of welfare services
   level of sexual activity
   teenage unemployment
   amount of schooling

Source: Family Planning Perspective, M/A, 1985

Particular Problems of the "Unborn"

1. No prenatal care

San Diego County Prenatal Care 1981-88

Year	1st Trimester	3rd Trimester and No Care
1981	78.7	3.6
1982	78.4	3.9
1983	76.9	4.4
1984	76.4	4.2
1985	74.0	5.0
1986	75.0	5.8
1987	75.3	6.3
1988	71.9	8.3

(Surgeon General's Goal for the Year 2000 is 90% in the 1st Trimester.)

Source: San Diego County Vital Statistics, 1988 Data Provisional

2. Perinatal Substance/Abuse

Results of drug and/or alcohol during pregnancy

° The use of alcohol, stimulants and cocaine as well as heroin and PCP result in a variety of devastating perinatal problems including:

____ birth defects
____ spontaneous separation
____ placental separation
____ prenatal and postnatal growth retardation
____ low birthweight
____ prematurity
____ neonatal drug withdrawal
____ mental retardation
____ fetal alcohol syndrome (FAS)
____ increase infant death due to Sudden Infant Syndrome (SIDS)

° Professionals (i.e., special educators, counselors, etc.) working with children exposed to alcohol and/or drugs in utero describe these children as evidencing such problems as:

____ Learning problems
____ Speech and language delays or disorders
____ Social-emotional delays or difficulties
____ Delays or problems in gross and fine-motor development
____ Attention deficits

PREPARED STATEMENT OF WINNIE WILLIS

Chairwoman Boxer and members of the Committee: I am pleased to present testimony on the issue of African American infant mortality. I am Winnie Willis, Professor of Public Health at San Diego State University.

The problem of infant mortality among African Americans is directly related to the incidence of low birthweight. Therefore all strategies for prevention of infant mortality must address the prevention of low birthweight. Data from the National Center for Health Statistics for the years 1983 and 1984 show that the low birthweight rate for African Americans was 12.7 % as compared to 5.6 % for whites, a two-fold difference; and that the cause specific infant mortality rate attributable to low birthweight was 224.6 per 100,000 live births for African Americans as compared to 62.1 per 100,000 for whites, nearly a four-fold difference. African American infant mortality, neonatal mortality and postneonatal mortality is twice that for whites: infant mortality (18.7 versus 9.1 per 1000 live births,respectively), neonatal mortality (12.2 versus 6.0 per 1000 live births, respectively), and postneonatal mortality (6.5 vs 3.2 per 1000 live births, respectively). M.H. Brenner, in 1977, proposed a theory about factors influencing health which serve as a framework for consideration of causality as well as approaches to solving this long term problem of disparity. It states that there is a relationship between national economic policy and health status, and further that apart from the economic interdependency of [family members] there is a diffusion of psychological stress generated by economic trauma. The relationship between economic policy and health status is illustrated in a 1984 report of the Urban Institute which states that "between 1980 and 1984 blacks of all income classes suffered declines in their incomes and standards of living...the average middle class black family has a lower standard of living in 1984 than in 1980, just as the average poor black family ...there has been a widening income inequality between blacks and whites since 1980." The national economic policies of that administration included cuts in programs such as AFDC, food stamps, subsidized housing and job training, which have a direct impact on the wellbeing families, especially pregnant women and infants. It was during this same period when it was observed that the infant mortality gap between African Americans and whites was also widening. The effect of stress generated by economic trauma is described as not only that related to unemployment, but related to the fear of unemployment ,and underemployment. Another particular characteristic of the 1980-1984 years was the continuation of the problem of disproportionate unemployment of African Americans: from 14.4% in 1980 to 16% in 1984, while white unemployment declined slightly during that time. The number of African Americans in the category of long-term unemployed (out of work at least half a year, and still looking) increased 72%, as compared to 1.5% for whites. Stress can be linked to alterations in eating and self care patterns which are so critical to the progress of pregnancy. In addition

there is dissipation of energy needed for maternal and fetal wellbeing in simply trying to cope. There is also research being done which suggests that stress may be implicated in premature births, hence low birthweight. In this country lack of employment or underemployment means no health insurance, without which access to good prenatal care is severely limited, in spite of the access that Medicaid has provided for those without a means to pay. The Medicaid eligibility and provider satisfaction difficulties have not yet been effectively addressed. Due to their poor economic status, many African Americans live in the areas where poor housing, crime, and lack of access to the usual public services is common, but these underlying issues can be ignored or overlooked if race is given as the explanation for adverse health outcomes. Therefore, effective strategies to affect infant mortality among African Americans must include policies and programs which support the life of the family. The best prenatal care program, if it focuses only on the pregnant woman without regard for her family context, will have less than he desired effect. Some people, including professionals, really do not see the relationship between incarceration of a family member and poor pregnancy outcome, or unemployment and poor pregnancy outcome. The experience of some of the states and local areas has been that women of similar economic class regardless of race have similar pregnancy outcomes. This also points to the influence of economics on lifestyle and access, which is probably an intergenerational effect. The Better Babies Project in Washington, D.C., the Healthy Baby Project in Detroit, and the Women's Health Line in New York City are examples of strategies designed to attract and enroll women in high risk groups and high risk geographic areas in prenatal care. These projects can serve as models for other communities.

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PREPARED STATEMENT OF BLAIR L. SADLER

The honorable Barbara Boxer, it is a pleasure to appear before you and the Budget Committee Task Force on Human Resources, on the subject "Health Care Crisis -- Problems of Cost and Access."

As we meet today, 141 sick and injured children are inpatients at San Diego's Children's Hospital, including:

...Three Kids with measles

...A little 18-month-old who nearly drowned last week in a backyard pond

...And a two-pound baby boy born prematurely with cocaine in his system.

Another 115 children are being treated in our outpatient clinics for anything from broken bones to cancer. And 54 are long-term residents of our Children's Convalescent Hospital, which now has a five-year waiting list.

Today in San Diego -- Today in America's finest city:

--173 children will be reported as abused or neglected;

--11 babies will be born with alcohol or drugs in their systems;

--8 San Diego teenagers will get pregnant;

--and today 10 women in San Diego will give birth without receiving any prenatal care at all.

These facts are merely a snapshot of what's happening across the nation. The status of child health in the United States -- and in San Diego -- is critical and the prognosis is poor. What a legacy we are about to leave the next generation, unless we make some significant changes. During the past 50 years, substantial improvements in children's health have occurred -- almost predictably -- from one decade to the next. So back in 1980, it didn't seem unreasonable when the U.S. Surgeon General set some important goals for improvements in child health to be achieved by 1990.

And yet during the 1980's, the United States failed to meet nearly all of the Surgeon General's 16 goals set for our children's health.

Unfortunately in recent years, even past gains have begun to erode seriously. It's now clear to me that the 1980's will be known as the decade America forgot its children. And that's a tragedy.

- The number of uninsured children nationwide has increased 13 percent in the last five years.

- Babies whose parents have no health insurance are about 30 percent more likely than those from insured families to die or be seriously ill at birth.

- Forty thousand babies born in the United States this year will die before their first birthday.

As unbelievable as it may seem, a baby born in Spain or Singapore, or 20 other countries, has a better chance of reaching his first birthday than one born in San Diego.

For those who do survive, immunization rates for children under two years are actually declining. Only 60 percent of children under four have received the complete, basic series of immunizations. In fact, the proportion of children being immunized has actually begun to decline, while cases of mumps, whooping cough and measles have risen. We are inviting the return of epidemic diseases that we had worked so hard to conquer.

- The Surgeon General predicted child abuse would drop 25 percent in the 80's. Yet abuse reports and deaths have skyrocketed.

- Nationally, injury (accidental or otherwise) has become the leading cause of death for kids between the ages of five and 14.

- In 1980, no case of pediatric Aids had been diagnosed. Yet during the 1990's Aids will become the fifth leading cause of death for children.

- And teen suicide is now the third leading cause of death for kids 15 and older, with deaths more than doubling since 1960.

One young person in this nation commits suicide every one hour and 38 minutes. Indeed, the facts are alarming. It would be nice to think these problems only happen elsewhere. But these problems are threatening the health of children right in our own backyard. As the only San Diego hospital dedicated solely to treating children, I can assure you that the health of our children is under siege. Spending even a few hours in Children's Trauma Center, or one of our pediatric intensive care units, would convince you of that fact.

- This year 3,000 San Diego teenagers will have babies of their own. Often these babies are born weighing less than a Sunday newspaper. And they're dependent on newborn intensive care unites to survive. (California, by the way, holds a very dubious title: We have the second highest adolescent pregnancy rate in the nation.)

- This year, 4,000 San Diego babies will be born with alcohol, marijuana, cocaine, heroin or crystal meth in their system.

It's estimated that one of every 10 pregnant women in San Diego abuses alcohol or drugs. If the baby doesn't die from the drugs, they may be faced with brain damage. And the cost of treatment for an infant's narcotic withdrawal? It can top $30,000. Costs for the special services required to threat fetal alcohol syndrome over a lifetime may run over 400,000. These babies are born addicted. They never had a chance to just "Say No."

In terms of child abuse and neglect, last year nearly 68,000 calls were referred to San Diego's Child Protective Services via the Child Abuse Hotline. This represents a 450 percent increase since 1982.

It's hard not to be affected when you read about two little brothers being beaten and abandoned. In this particular case, at Children's we couldn't even tell they were twins at first. It's hard not to be affected when you read of children being sexually abused. Or when you hear about a badly bruised toddler with rope burns on his legs. An 18-month-old with a broken right arm and broken left leg - which had been broken and unreported six weeks before he was brought to Children's by life flight unconscious and near death. Even relating these stories is upsetting to me. And these cases go on all the time. 68,000 reports last year. Each representing a child, a family. Far too many times the abused child becomes the abusing parent. It's a cycle that must be broken.

- In 1987 alone, 27 San Diego children under the age of four died from confirmed or suspected child abuse.

Among the risk factors affecting children's health, none is more shocking than this intentional abuse and neglect. Another form of this neglect confronts some san Diego children even before they're born. The problem is the lack of prenatal care.

- Each month 300 women arrive at San Diego hospital emergency rooms here to give birth without ever seeing a doctor.

- In San Diego, 10 percent of all babies are born to mothers who received no prenatal care -- some by their own choice.

Others because they can't find care. It's a fact, that less than one in five San Diego Obstetricians accept Medi-Cal Patients. Government reimbursement is very low and the malpractice risks very high. With the highest rate of these "no-care" births in California, incredibly San Diego county spends less per capita on prenatal care than any other urban county in the state.

- Mothers who receive no prenatal care are four times more likely to give birth too soon. And their babies may suffer a variety of serious health problems, which can cost $2,000 a day to treat -- far more costly than prenatal care would have been.

Other threats to our kids?

- One in five, between the ages of 14 and 17 in the United States are problem drinkers. Last year in San Diego County, 66 percent of high school seniors said they were regular alcohol users, 53 percent had used marijuana and 19 percent had used cocaine.

Incredibly today, the average age for first-time drug use is 13. The average age for first-time alcohol use is 12.

- In 1988, 20 San Diegans age 14 to 19 killed themselves. This was up dramatically from the previous year's total of nine.

Last year it's estimated young people in San Diego made between 2,000 and 4,000 suicide attempts. As a parent, the thought and reality of teen suicide is terrifying. Each week at Children's we work with teens in our Child Guidance Clinic - helping kids who want to die, want to live. How unnerving it would be as a parent to receive a call from a friend of your 15-year-old son ...

to learn that he's been talking at school about killing himself..

To hear that he's actually loaded the gun -- your gun -- and put it in his mouth.

And yet that friend's call probably saved the life of one of our young patients.

Watching for the warning signs is so important. This young man didn't think his mom cared. But she did. and does.

If children are our future, and their future is jeopardized by threats to their health and well being -- it's clear our future is in trouble. This is not a liberal or conservative issue....or a democratic or republican issue. It is a fundamental American issue. All children deserve a healthy start because it is right!

All children deserve a healthy start because they are our future work force! (How are we going to be successful in an increasingly competitive world economy if we aren't turning out healthy children who have the capacity to learn, to be self-sufficient, to reach their full potential). Quite simply, investing in the health of our children is the single best investment we can make!

With so many threats to child health, it's little wonder that our children's hospital has a nearly 90 percent occupancy rate. It's also little wonder that some days we don't have enough beds, causing us to turn away kids. Because we believe so strongly in our mission -- "To restore, sustain and enhance the health and developmental potential of children" -- Children's Hospital, has launched a year-long public service program to increase awareness of these child health issues.

We're asking all San Diegans to be Children's Partners in Caring -- for our Children. We've developed a special kit that gives the straight facts about the problems. This Partners in Caring Kit is available at no charge simply by calling Children's Hospital

Our children's future is in our hands. Soon our future, and that of the nation will be in theirs. They are our most precious resource.

If we are to avoid repeating the tragedy of the 1980's where we literally forgot our children, we must make a fundamental commitment to their health and well being now -- for our children -- in the decade of the 90's and beyond. What better time to make a major and lasting commitment to the health of our children than as we enter a new decade, and approach a new century.

Thank you again for the opportunity to appear before your committee, for your interest in children, and for caring.

PREPARED STATEMENT OF SUSAN HOEKENGA

Introduction

Ann is 83 years old, Mary is 87. Ann's recovery from minor eye surgery turned into a nightmare for her, when she was sent home with three prescription eye drops all the same size and shape and all with varying dosages. She received no home health care, no in-home support services and after several days alone, she contacted ElderHelp of San Diego which arranged a safety net of medical and personal care services until she recovered.

Mary was not so lucky. Her income of $675 required her to pay $50/mo in shared costs toward 24 hour/day oxygen therapy. She had breathing problems for decades, and was diagnosed with emphysema and an ulcerated esophagus when she was 80. ElderHelp of San Diego arranged for groceries to be delivered, and completed the Department of Social Services "share of cost" requirements, we also assisted her in obtaining several hours per week of Area Agency on Aging Title III homemaking services, but she spent 90% of her time alone. With no one there to help most of the time, in essence Mary's life consists of trips back and forth to the hospital where she is admitted with breathing seizures. She has been hospitalized as many as three times in one month.

Statement of the Problem

These examples point out three major failures of our healthcare system for the elderly.

1. Lack of access to coverage for preventative measures under Medicare. The Medicare handbook specifically states that physical examinations are not covered, nor will they pay for hearing aides, eye glasses, or podiatry - conditions which affect many seniors. We have clients who can not see and can not hear, because they cannot pay for it.

   The travesty of a system which denies basic medical coverage for the low income elderly is perfectly related in Mary's story. Because regular doctor visit were not covered, she did not gain access to medical services until she reached the most acute stage - a chronic condition requiring ongoing hospitalizations.

   Another side of access problem is that even if preventative measures were covered many elderly lack transportation to get to the doctors office

2. Ann's story points out the second problem with access. Neither Medicare nor MediCal will pay for in-home care other than home health care. Ann receive neither because although she was eligible to be placed in a skilled nursing facility, she instead chose to recover at home. There is no provision for seniors released from the hospital to receive essential, non-medical services and without these simple chores like cooking and cleaning and bathing, their chance for a healthy recovery is substantially reduced. Surely if we had a health care system that worked Ann could have had a daily worker for a fraction of the cost of nursing home care.

3. The two examples also highlight a third important problem with our healthcare system, and that is the incredible strain placed on community based agencies to provide essential, non medical services for low income elderly. ElderHelp's grocery shopping program serves about 50 seniors a month. There are close to 25,000 seniors in San Diego who need this service. Our Case Management program which weaves together a safety net of community services - meals, escort, transportation, and in-home support serves 100 seniors per year. It is funded in part by the United Way of San Diego, which devoted less than 3% of $25 million raised last year in support of needs of the elderly.

Solution

The recent federal budget crisis pointed out how difficult it is to alter the Medicare system, yet I would urge members of Congress to examine the cost allocation process within this program to ensure these funds are being spent in the most cost effective way possible. Denying access until medical problem are acute is not cost effective. Denying community support services over skilled nursing care for elderly being released from the hospital is not cost effective. Denying diagnosis and treatment for preventable health problems is not cost effective. The billion dollar Medicare system we finance is not cost effective.

The Task Force on Human Resources should call for a GAO study to evaluate the potential cost savings of authorizing Medicare benefits for health prevention services; specifically look at acute instutionalization of the 80+ population to see what percent of the hospital and skilled nursing facility admissions could have been served more effectively at a less acute level of care.

We would also ask the Task Force to evaluate the Medicare policy which states that patients may receive up to 8 hours/day for 21 or more days of authorized home health care. We know of not one person in 20 years at ElderHelp where a client received 8 hours of daily care.

Finally, amend the Medicare rules to allow reimbursement for essential non-medical, at-home services enabling seniors to be released back to the community with a "safety net" of services - case management, shopping, laundry, cleaning, transportation and escort.

Financing

Medicare is the biggest provider of services to the elderly and an evaluation of the financing must begin with a review of this system. Particularly important is consideration of a means-tested eligibility for Medicare for those with income of $25,000 or higher.

In addition, explore employer incentives for health care benefits to employees age 55 and over; and package benefits for the elderly similar to child care programs.

Conclusion

Problems of cost and access have created a social, economic, and political crisis in this country. The oldest of the old now comprise the fastest growing segment of the population, and for the first time in history, the U.S. has more senior citizens than teenagers. What our health care system will look like when today's teens reach their golden years, must begin today, or the future truly will be scary for all of us.

OPENING STATEMENT OF HON. VIC FAZIO

I want to thank my colleague, Congresswoman Barbara Boxer, for holding this field hearing in Sacramento. As a former member of the House Budget Committee, who served with her on that panel for four years, I know how dedicated Congresswoman Boxer is to addressing our country's health care needs. And while Sacramento is similar to many other medium-sized cities across the country, as a growing city and county, we also have unique health care problems regarding the cost and access to health care.

Although I would like to stay for the entire hearing, a previous commitment prevents me from participating in all of today's panels. However, I would be especially interested in hearing from the witnesses on the maternal and child health panel, which I understand will include testimony on the preventive benefits of the Special Supplemental Food Program for Women, Infants and Children, or WIC program.

As a senior member of the House Select Committee on Hunger and the House Appropriations Committee, I have been particularly involved with the WIC program to ensure that it serves as many nutritionally at-risk women, infants and children as possible. WIC is an effective first line of defense against infant mortality, low birth weight, malnutrition and other health problems associated with inadequate nutrition among American children.

Unfortunately, however, serving all eligible women, infants and children is a matter of cost. Despite public and congressional support for the program, budgetary constraints continue to serve as the main obstacle for reaching all of those in need. Even with our best attempts, WIC only serves between 50 and 60 percent of eligible individuals, and in many states, including California, far less are served.

Congress has been working to improve access and make this program as effective as possible. Over the past ten years, we have increased funding by more than $1 billion over administration requests, and this year, we have directed the Department of Agriculture to work closely with state WIC directors and Congress to ensure that the program does not have to drop individuals from participating due to unexpected increases in foods, such as orange juice.

Again, I look forward to participating in this hearing and I commend Congresswoman Boxer, Supervisor Grantland Johnson, Mayor Anne Rudin, and all of the witness for their concerns about health care in Sacramento.

PREPARED STATEMENT OF DR. GIL SIMON

THE SACRAMENTO CHILDREN'S MEDICAL CLINIC

The Sacramento Children's Medical Clinic was begun January 1 1989 in order to provide quality specialty care to medically under-served, economically disadvantaged children. We quickly recognized that the neediest families were least likely to have reliable transportation, and that our being available for them was meaningless if they had no access to our facility.

We decided to bring our office to them by developing a series of out-reach programs. If no space is available in the out-reach site, we bring our mobile unit, the Clinic on Wheels, a converted family RV. In October 1990, our Clinic on Wheels visited twenty different sites in Sacramento and West Sacramento and performed 328 examinations.

Other mobile models include the use of multiple stations when more than fifty children are to be examined. This was the model used in performing examinations in Migrant Camps. For less than ten examinations, we use our M.A.S.H. unit (Mobile Assessments for School Health). In all situations, as a privately owned and operated practice, we bring our own materials, equipment and staff.

Being a Pediatric practice, we only see infants, children and teenagers, and since our goal is to reach the under-served, we are not interested in seeing children who are already established with a doctor. We come as often as needed.

We come equipped to do the complete health screening exam required by the state Child Health and Disability Program. In the mobile unit, we are also prepared to diagnose and treat roughly ninety percent of illnesses. We do rapid Strep antigen screening in the COW.

We accept Medi-Cal or the Children's Health and Disability Prevention (CHDP) reimbursement as payment in full. We receive no grants and are in no way connected to any governmental agency.

Once the child has been seen, he becomes a Sacramento Children's Medical Clinic patient, and his chart is kept in our active files in one of our offices. If the parents wish an appointment at one of the two offices, they need only call us at 422*BABY for the Florin Road office, or 923*BABY for the North area office. Both offices are situated in inner city low income communities. Of course, if they have no transportation, they can continue to have all their visits in the mobile van.

To address the cultural barriers to access, we have developed a multilingual support staff and a network of interpreters. We are also experimenting with different scheduling techniques designed to accommodate the special needs, attitudes and habits of the long term poor.

We have formed a subsidiary organization, The California Children's Medical Clinic, to replicate our Sacramento program in other parts of California. An office in Santa Rosa administers the mobile outreach program in Napa, Sonoma and Marin Counties.

In addition, we are awaiting approval of our application for tax*exempt status for our corporation, Access For All. Its objective is to raise funds to support research for the development of innovative techniques for the improvement of access to health care.

The Sacramento Children's Medical Clinic will perform eighteen thousand examinations in 1990. In a brief period, we have substantially changed the health status of children in several communities in Sacramento and plan to extend our program to other medically underserved areas in the coming years.

OCTOBER 1990: CLINIC ON WHEELS

PROGRAM	NUMBER CHILDREN
SCHOOL	
DOS RIOS	9
BABCOCK	14
CASTORI	21
NORTHWOOD	5
HAGINWOOD	17
ROGERS	17
ROGERS	8
SMYTH	14
WOODLAKE	9
JOHNSON	11
RUSSIAN COMMUNITY	
EDISON	1
AMERICAN RIVER	8
BRYTE	20
COBBLESTONE	14
BRYTE	7
HEMLOCK	15
ASIAN COMMUNITY	
N. HIGHLANDS	20
N. HIGHLANDS	16
HISPANIC COMMUNITY	
ZAPATA PARK	21
PINE ST.	21
KENNEDY ESTATES	20
SHELTERS	
SOUTH AREA EMERGENCY	12
TOTAL	328

INSUFFICIENT FUNDING TO ACHIEVE OBJECTIVES

PROJECTED PARTICIPATION RATES FOR CHDP EXAMINATIONS

County	Total Target Population (1)	Children Receiving CHDP Assessments (2)	%
Napa	14,761	1,980	13
Marin	21,768	2,452	11
Sonoma	54,950	8,799	16.
Lake	9,839	2,841	29
Sacramento	190,871	41,234	22
Statewide	5,095,680	959,409	19

(1) Department of Health Services. Child Health and Disability Program. Estimated Target Population Fiscal Year 1989*90.

(2) Child Health and Disability Prevention Program, California State Department of Health Services 03/05/90.

Assuming that only half the target population will be eligible, by periodicity, for a CHDP examination in 1990*91, and that the number of children getting examined will remain the same in 1990*91, then the number of ELIGIBLE TARGETED children who will not get examined in 1990*91 will be 1,588,431.

ADDITIONAL COSTS

1. Removing all barriers to participation would increase the number of children receiving a CHDP examination by 166 %.

2. Under provisions of 1989 Omnibus Budget Reconciliation Act, states must provide services required to treat any condition identified during a EPSDT (CHDP) screen.

BARRIERS TO FULL PARTICIPATION

1. Inaccessable Care

   a) lack of reliable transportation
   b) language and other cultural barriers
   c) fear of officials
   d) long waits
   e) infrequent and irregular hours

2. Cultural Disengagement of the Long Term Poor

   an inability or unwillingness to utilize the institutions of the dominant society. Examples: not attending prenatal clinics, not applying for WIC, not seeking immunizations or routine medical care for their children EVEN WHEN READILY AVAILABLE. Disengagement believed to be the single most important characteristic of the culture of poverty.

3. Insufficient Funding of Existing Programs

   current level is marginal for the twenty percent who participate.

RECOMMENDATIONS

1. MOBILITY

   a) eliminates transportation barrier

   b) going to their "turf" serves to engage the disengaged.

2. MONEY

   must provide funds for FULL participation.

3. MOTIVATION

   a) public health: set high level of participation that must be met; sanctions and rewards for performance.

   b) private sector: start up grants, no interest loans , support for nonreimbursable costs that are normally borne by public agencies, participation in purchasing power of public agencies, "favored" status during periods of budget impasses.

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From the Publication HIV 2000
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Presented at hearing on Women and AIDS, Nov. 5, 1990

HIV and Women

The World Health Organization (WHO), has estimated that by the end of 1992, a cumulative total of 350,000 women will have contracted AIDS - three times the number at the end of the 1980's. Women now account for a growing proportion of AIDS cases, partly because the spread of HIV infection among gay and bisexual men is slowing and partly because of increasing rates of infection among the heterosexual community. Approximately six million people world-wide are now infected with HIV, two million of them women. [Lancet 2/3/90]

By 1991, the proportion of cases of women with AIDS is projected to account for about 10% of AIDS cases in this country. [JAMA 3/3/89] As of June 1990, women comprise 7% (3,653) of the CDC reported national AIDS cases.

In June, 1990, the Sacramento AIDS Foundation had over 400 clients, 44 or 12% were women. Of these 44 women 56% are Caucasian, 29% are Black, 11% are Hispanic. The majority of these women live in Sacramento County, with one each residing in El Dorado, Placer and Yolo Counties. They range in age from under 13 to over 49 with 89% between 20 to 49. Fifteen women are HIV positive, 20 are symptomatic and 9 have AIDS. IV drug use, at 46%, and Heterosexual contact, at 26%, were the primary modes of HIV transmission.

Current Women and Children HIV Data
(Mark Starr, Sac. Co. Epidemiologist)

As of August 30, 1990 there are have been 518 cumulative reported cases of AIDS in Sacramento County since 1981

- 17 (3%) female
- 5(1%) less than 20 years old

IV Drug Users and AIDS Percent IVDU's for:	Sac Co.	Calif.	U.S.
All cases	7%	5%	21%
Female	44%	33%	50%
Black	19%	15%	40%
Hispanic	20%	7%	40%

The following needs reflect primary HIV and AIDS health access issues for women in the larger Sacramento area:

1. Women who are most at-risk for HIV are from low income, cultural groups who are struggling with other daily living issues such as food, shelter and chronic unemployment. AIDS is often the least of their worries, as they are preoccupied with surviving.
2. Women who are substance abusers are reluctant to seek rehabilitation because facilities that are supportive of their family conditions do not exist (for example, pregnant women or mothers with children). Women who need to be educated about HIV must trust the "system". They must value their own health and well-being enough to desire change and enact preventive behaviors.

3. Under-diagnosis of HIV-related illness among women is a serious concern. Symptoms that would warrant HIV testing are typically treated in primary care settings as 'regular' illness, with Pneumocystis Pneumonia often under-diagnosed. Upper respiratory and genital infections, that are indicators of early stages of the disease among gay/bisexual men (pneumonia, thrush), are often overlooked by health care providers when treating women.
4. Special characteristics of women with HIV infection in the Sacramento area include;
   - Most of HIV infected women are head of household;
   - A disproportionate number are women of color;
   - Women wait longer to seek services and treatment;
   - Most are low income;
   - Most lack social or family support systems;
   - Many women with children delay professional help because of fear of separation from children and/or that children will be split up into foster homes;
   - Women clients have intense case management needs and require a high degree of involvement by multiple health and social service agencies;
   - Most lack transportation, which impedes access to medical and social services;
   - Most of the women come from dysfunctional families (i.e., drug abusive, physically abusive, etc) which impairs their problem solving abilities;
   - Many of these women have a general mistrust of the health and social service system because of previous discrimination and prejudice;
   - Many women lack the personal skills to access health care;
   - There is a general denial of the possibility of HIV infection, "I know but I won't tell you".

Women's issues in case management include:

1. Of the cases studied, these women required almost one social work contact per day for the first two months of case management services (SAF case load).
2. Of the women studied, each required an average of ten referrals for services or to agencies including; financial assistance [AFDC, SSI, GA, Food Stamps,] housing [HUD] legal assistance [wills, durable power of attorney], child protective services, counseling, respite and child care services, medical providers [Medi-Cal], funeral services and planning, volunteer support service, hand-to-hand, home health care, hospice, county mental health, suicide prevention, etc.
3. The seroprevalence data on HIV infection in women is important for several reasons. First, given the long incubation period between infection and overt illness (7 - 11 years), the current number and percent of AIDS cases in women may not accurately represent future epidemic trends. Second, the seroprevalence rate in women is a potentially useful marker to assess the extent of infection spread by heterosexual and other modes of transmission. Third, the major source of pediatric AIDS is perinatal transmission from infected mother to child; seroprevalence studies in women of childbearing age can assist in predicting perinatal infection trends. Finally, seroprevalence information can help identify specific populations and geographic areas for which counseling and testing, targeted education programs, and other prevention efforts should be increased, and can help evaluate the efficacy of such interventions.

What makes HIV infection different for women?

The profile of HIV-positive women includes isolation from family and community, lack of medical care, counseling, child care, housing, hospice, and respite care. If she is chemically dependent, she may have very poor self-esteem and may be leading a lifestyle that involves a certain degree of criminality. HIV positive women are faced with the burden of hard personal decisions about conception, and continuation or termination of pregnancy. Further, many of these women are alone or come from families where the level of psychosocial dysfunction is so great that there is no positive support system. Many of the cofactors associated with AIDS are known to exist in drug users, and include poor nutrition, use of drugs known to suppress the immune system, repeated bouts of infection, and high stress. Chemically dependent women are at increased risk for the following medical problems: infections, anemia, sexually transmitted diseases (STDs), hepatitis, hypertension, diabetes, urinary tract infections, gynecological problems, and dental disease, including abscesses.

There are three specific health care areas that affect women with HIV infection primarily.

1. The first is respiratory infections. When women seek health care for respiratory problems, their risk for HIV is not being assessed. The serious respiratory problems that affect women with HIV infection are not being diagnosed and are under treated until much later in the course of the disease. As a result, morbidity and mortality are much higher than for men with the same symptoms.

2. Gynecological infections. Risk assessment for HIV infection is not being ascertained when women seek health care for gynecological problems. 80% of Male IVDU's have their primary relationships with women who do not themselves use such drugs. Gynecological problems in HIV-Infected women include pain in the lower abdomen (chronic pelvic infection); vaginal, ovarian, and cervical abnormalities; candidiasis; ovarian, abscesses; amenorrhea; menorrhagia; sexually transmitted diseases (especially syphilis, gonorrhea, and herpes); and vaginitis. Women are seldom assessed or tested for HIV infection when they come for treatment for these conditions.

3. The third most common health issue is by far the most controversial; women who are HIV infected and planning pregnancy, already pregnant, or seeking birth control or abortion. There is evidence, in both national and international studies, that a pregnant woman who knows that she is HIV infected will seldom alter her decision to have the baby. The evidence is that she will not only have the baby, but will continue to have other babies.

PREPARED STATEMENT OF DR. BETTE G. HINTON

As the County Health Officer in a County of one million people, I appreciate your willingness to listen to us and attempt to help us to provide solutions to an ever-growing need for health care for the children of Sacramento County. Although we live in a County with a rapidly growing population, and therefore a rapidly expanding budget-State and federal funding cuts, an expanding medically needy population and a lack of understanding of the value of preventive care, have left us with worsening health indices and no apparent relief in sight. I would like to speak to you briefly of the gaps in services to children from conception to the age of majority.

An infant conceived in Sacramento County is increasingly likely to be conceived to a mother who is either unmarried, a teenager, poor, drug using, non-English speaking or a combination of the above. If, as is the case for 41% of our pregnancies and 72% of our teenage pregnancies, the mother is eligible for Medi-Cal, she faces increasing difficulty in finding care since the number of obstetricians who are practicing is decreasing, as is the number who will accept new Medi-Cal patients. We need help to both adequately fund and decrease the bureaucracy of the Medi-Cal system and to encourage physicians to practice in this field.

If the aforementioned mother is accepted into care and willing to participate, there is very little support for her in the community. She will likely have difficulty with transportation, health care will be located outside her neighborhood area and will not be culturally sensitive and the public health system will offer her almost no assistance. Except for one small project, public health

field nurses are not available. If she needs extensive assistance, only two small community based organizations funded by private foundations can offer to help. In one of our hospitals, there is a 20% likelihood that she will deliver her baby with no prenatal care. If she is eligible for WIC there is only a 20% chance that she will be served and no chance of service to her child after the age of 1. The odds that her baby will die before the 1st birthday have been increasing since 1986, especially if she is black. We need financial help and renewed interest in prevention to see that this doesn't continue to happen. WIC must be adequately funded and we must begin to rebuild our public health infrastructure which has been severely damaged by the emphasis on acute care.

A child born in a hospital in Sacramento to such a mother is accepted into pediatric care. In this area, we have acceptable access. However, if the child comes to Sacramento after the time of birth, access to care if he is poor or Medi-Cal eligible is much

more difficult. We do not have the public health resources to provide outreach to these children, federal funding of immunizations is inadequate, WIC services are unavailable and our children are suffering.

In Sacramento, our neonatal death rate is generally lower than the State average; however, our infants die at a higher rate than other Californians from age 1 month through 11 months. We must be lacking adequate services for these children. Of the 140,000 children eligible for CHDP services through Medi-Cal, only 40,000 access them. Only 14% of those eligible through the extended CHDP eligibility participate. Only 1/3 of our children eligible for Denti Cal are using it, in a community without a fluoridated water supply. Children under 2 years of age, and older children who are new to dental care, have an extremely difficult time in finding even emergency care because the Denti Cal program is so poorly funded and managed.

Vaccine preventable disease outbreaks are on the rise. We are experiencing both measles and pertussis outbreaks. Yet, federal and State funding for any but the most minimal of immunization programs is lacking. In the past two years, we have had deaths from these diseases which are entirely preventable.

As the child progresses in age through our "non system" of health care, he becomes less and less likely to find adequate, humane services. Medi-Cal is inadequate, financially strapped counties discourage state-responsibility patients, and a vocal minority of our citizens are blocking good preventive health care programs. Attempts to place clinics in schools, fluoridation and immunizations are viewed with suspicion. Sex and AIDS education are discouraged and the cycle begins again with a teenage mother or a 25 year old AIDS patient who was infected with HIV in the teen years.

The federal government must lead the way to return us to common sense prevention and health care for **all** children regardless of income. Their public health system needs to be bolstered, their environment protected and their medical needs met while they are young and growing so that the next generation of voters can be productive citizens.

Thank you for your attention.

PREPARED STATEMENT OF CYNTHIA BURNETT

To Combat the Spread of HIV Among Women in the United States, and Provide Health Care for Women Living With HIV Disease

"WHAT IS NEEDED - AT A MINIMUM"

1. The virus has become so pervasive in particular communities in this country, that all community based AIDS education and prevention activities necessitate a provision of direct client services, which will include at a minimum, guided referral, assistance for receiving HIV antibody testing and psychosocial support.

2. To serve the broadest segment of the HIV positive population, (specifically the poor, working poor and people of color) all health care providers involved in the treatment, support and medical care of women infected with HIV, should incorporate advocacy and support for [anonymous] testing as components of education, prevention and early intervention efforts.

3. Comprehensive medical follow-up for all high risk infants.

4. The recognition and establishment of a the broader definition for "the people at risk for HIV infection". The definition should include people who are predisposed to contracting the virus, via behaviors such as crack use and related sexual exploitation, as well as living in environments where there is the potential sexual abuse. An integration of these co-factors should be included in the development and implementation health services for women.

5. Funding for mental health services for women with HIV disease, their children and infected children.

6. Residential Shelter Provisions which can accommodate the entire family by allowing the male, female and children to remain together, including those circumstances where only one parent is infected.

7. Clinical trails should be more accessible to the poor, the working poor, women and children. This means integrating cultural, socioeconomic and gender sensitive information in the development of research projects and the selection of trial participants.

8. Mandatory continual learning hours on HIV disease patterns and treatment for public and private physicians working in public hospitals.

9. Expanded patient care and clinical research in poor communities. The working poor usually do not seek medical care until they are unable to work. The definition of access to medical care is narrow and policy and funding determinations are not made with poor communities in mind. Medical care, just like education and prevention efforts, need to be culturally, economically and geographically accessible. We need specialized neighborhood clinics, or the expansion of existing ones, for HIV infected patients in poor communities, and we need those clinics to provide specialized health care for female clients.

10. A realistic allocation of Federal funds for specific research into perinatal HIV transmission, prenatal care of AIDS patients, and uniform definitions and protocols for identifying HIV disease indicators for women.

The Cost of Care For Women Living With HIV Disease

Although the sum of $250 million dollars have been appropriated for the care of People With AIDS (PWAs), those monies have not been made available to states which are in desperate need. As the number of PWAs increase, we know that the number of HIV infected individuals is increasing, at rate of 8-10) persons for each PWA.

The early intervention medical model, provides an excellent opportunity to combat the spread of this virus. Current epidemiological data clearly depict the new causalities in this war. They are poor, the working poor, women, children and people of color. The very nature of this information demands an adjustment in how we [health care funding agents, policy makers and providers] define "early intervention". The socioeconomic disparity, cultural barriers and lack of care provider responsiveness, necessitate a more realistic approach to health care for people with HIV Disease.

AIDS education is desperately needed in rural, economically disadvantaged and all communities of color. Unfortunately, the educational efforts must be accompanied by intensive care of already infected individuals, who by and large do not have, seek or, receive medical attention until the virus has affected them beyond the ability of any early intervention program to be effective. In essence we [health educators and providers] must initiate and continue a health education campaign, in areas were people are dying daily of AIDS, yet were the community denies any vulnerability to the problem and the models for early intervention focus on treatment for individuals who are unaware of their HIV status.

To mandate the separation of direct service provisions from educational grants, based of the epidemiological data before us, is medically irresponsible and fiscally extravagant - and we can't afford to be extravagant.

The average cost of care for PWAs from AIDS diagnoses to death is $50,000 - $75,000, for an average time span of fifteen (15) months.

Statistics given by the State University of New York, Health Science Center of Brooklyn, estimate an annual cost to the taxpayer funded Medicaid system, of $18,000 - $42,000 for HIV infected infants!

The Health Care Financing Administration reports that federal funds pay for 70% of costs for IVDU AIDS patients, 52% of these patients indicate Medicaid as their only form of payment. In 1987 the average public hospital lost $600,000 in revenue to the treatment of PWAs. This tremendous financial burden is forcing many inner-city hospitals to cut down on the number of AIDS patients, perhaps compromise their services, and possibly turn to bankruptcy.

PWAs with private insurance are finding that their employers are switching to lower cost insurance and prescription drug plans which do not cover AIDS. Without such coverage, AZT - at an annual cost of $3,000 - $7,500 per patient - is prohibitively costly. The Ryan White Act of 1990 [CARE bill], will not provide much of the inpatient costs incurred by patients, on Medicaid and MediCal in public hospitals.

Cost Effective Alternatives

1. All federal and state funding for community based AIDS education and prevention programs must include a component of direct service, which would include, at a minimum, advocacy and assistance for HIV antibody testing, guided referral for medical services and psychosocial support.

2. In Sacramento, health insurance providers have seen a substantial decrease of approximately $3,000 per AIDS patient, as a result of utilizing hospice and home health care as alternatives to acute care hospital stays. [Hospital stays average $650 - $1,200 per day Nationally, while home health care averages $300 - $600 daily.]

3. Publicly funded midwifery services for HIV infected pregnant women could substantially reduce the cost of delivery and in most cases, prenatal care for women, as compared to the taxpayer cost of hospital care and delivery.

4. Clinical trails must be accessible to poor, working poor, women and children. It is a fact that not all drugs have the same effect when used by different races and genders (for example the minimal response of Blacks to antihypertensive Beta-blockers verse the more effective response by whites). Therefore, women, people of color and children must be included in AIDS clinical and drug trials to insure mass suitability and effectiveness. Research agencies, such as the National Institute of Allergy and Infectious Diseases (NIAID), must integrate an understanding of patient needs and socioeconomic factors for trial participation in the selection of research trial participants to enhance inclusion and drug useability in the broader population. It was not until 1989 that NIAID authorized $6 million dollars to community research clinics.

PREPARED STATEMENT OF CAROL CASADAY

In preparation for this hearing twenty people, representing Sacramento's Women and AIDS community, gathered to express concerns and issues they wanted addressed today. Following is a summary of that meeting.

1. "Middle class ignorance" allows women to believe that if they are married, have a family, and a job they are "above" getting AIDS and are immune to the virus.

2. Women with HIV fear that the medical profession doesn't know what they need because AIDS is a recent disease that has been found mostly in men. There aren't enough doctors who specialize in AIDS so they don't know women's symptoms and therefore are unable to make early diagnosis.

3. Women are excluded from clinical trials because of their reproductive capabilities and they are not being allowed certain medications that are effective in overcoming the extreme fatigue associated with HIV.

4. Effects of HIV/AIDS on children ranged from lack of knowledge about public assistance to death and adoption. One women's child was in a death support group because her husband died with AIDS but she was unable to discuss her own infection with her son. Women have difficulty making arrangements for the child's care after death of both parents. One woman did not want her family to get custody of her children because they used drugs.

5. Fatigue is a major factor that gets in the way of the woman's ability to care for her family and home and continue to work. Other medical problems such as pneumonia literally put the women out of commission for weeks. There isn't any in- home assistance for women with HIV and little assistance with child care. Respite care is only minimally available for parents who are at risk of child abuse. Women have a difficult time taking care of their children's medical needs. Very few dentists will take MediCal. Keeping medical appointment is difficult because of transportation, fatigue, and other medical complications, and having to get all the children out of the house.

6. Women are afraid of community rejection. They are afraid that their children will be rejected and poorly treated. One woman was afraid of losing her job, house, everything. She wanted support from her religious community but even the minister thought it was better for her not to tell anyone.

It is important to take a closer look at the relationships that are affected by a women who has HIV/AIDS. Those relationships are women and drugs, women and children/family, women and health care.

WOMEN AND DRUGS

Marilyn is 30 years old. She has been using drugs intravenously for about 12 years. She was diagnosed HIV+ a year ago when she was brought to jail because she was picked up for prostitution and possession of illegal substances. She has been in jail several times and was also in prison for petty theft. She came to one of the support groups our agency offers for women in jail. When she was released she came to the Chemical Dependency Center because she needed bus passes and some clothes so she could get home (she lives with her mother), and see to her probation officer. Our outreach worker referred her to CARES and made an appointment for her to attend our drug treatment intake group (she said she wanted to stop using). She never made it to her intake appointment because she was "too busy". The next time we heard from her she contacted our Outreach worker because she was picked up on a probation violation (dirty test). She was given a court hearing date but didn't show up because she "overslept".

There are many lifestyle issues that need to be addressed in understanding health care and treatment issues for women drug addicts.

1. Living moment to moment and lack of organization. Lifestyles are chaotic. Excuses such as "I overslept", "I didn't have any transportation", and "I couldn't find anyone to watch my kids" are all valid but reflect an inability to plan and get it together. Women are sincere about wanting to clean up and come for their appointments but it does take planning.

2. Drug addicts are trying to deal with a troubled past and chaotic present, while avoiding the future. They must deal with difficult survival issues but are generally alienated from social systems.

3. HIV/AIDS is a disease that people do not want to know about or deal with. It is possible to live with the disease without knowing you have it. If you know you have it you have to deal with it, take responsibility, stop using, have feelings.

WOMEN AND CHILDREN/FAMILIES

Women are often diagnosed HIV+ upon delivery of their baby. According to Dr. Hansen at UCDMC 50% of the mothers who are HIV+ are asymptomatic at the time of delivery and are diagnosed when the baby has symptoms, which may be up to 18 months after birth (although it is possible that pregnancy and childbirth may increase the risk of AIDS). 80% of the children with AIDS are born to mothers who have a history of IV drug use or who are partners of IV drug users. Although 60% of the babies born to HIV+ women escape infection, many have been exposed to drugs and are extremely high risk for developmental disabilities. Women who have used drugs during pregnancy, or whose baby is born HIV+ have to care for a child who may have many problems and who needs a great deal of special attention.

Addicted mothers often have feelings of extreme guilt, anger, and failure. Like other women, addicted mothers consistently express concern, care, and guilt about their role as mothers and the well being of their children. Motherhood may be central to their identity because it is the one job they can do. Because of the relationship with drugs, however, motherhood too is a failure (Rosenbaum, Marsha, "Difficulties in Taking Care of Business: Women Addicts as Mothers", Am. J. Drug & Alcohol Abuse, 1979).

When a child is told about a life threatening illness it can be catastrophic but when that parent has AIDS there is also a great deal of confusion, lack of comprehension, social isolation, emotional distress, sense of deep shame, and blame in learning about the mother's behavior. In addition the woman may also risk losing the man she is dependent on who may be supporting her in some way.

A woman is trapped by a system that makes her feel responsible for the care of her children even when she is unable to care for herself--and compounds her problems by reinforcing her view of herself as a "bad mother" if she leaves them to seek help (Russo & VandenBos, "Women in the Mental Health Delivery System" in W.H. Silverman(Ed). A community Mental Health Sourcebook for Board and Professional Action, N.Y., Praeger, 1981).

WOMEN AND HEALTH CARE ACCESS

Many studies correlate low socioeconomic status, low educational level, and poor degree of social integration with receipt of medical care that is poor in both quantity and quality. Poor women's relationship to the health care system has been mainly as passive recipients of medical interventions, as dependent patients to dominant providers, and having no bargaining power (Marsha Hurst & Ruth E. Zambrana, "The Health Careers of Urban Women: A Study in East Harlem", Journal of Women in Culture & Society, 1980 V5 No.3).

Under-utilization of medical and health services is affected by financial resources, culture, and the health care system itself. Women must respond to the care of herself and her family using a white male affluent health care delivery system. Sex bias and sex role stereotyping affect the nature, diagnosis and treatment of health problems. Services are not based on women's diverse individual and cultural needs. For example, early diagnosis for HIV is being overlooked when women experience symptoms that are not yet recognized by CDC as AIDS defining diagnosis; i.e. chronic vaginal yeast infection, cervical abnormalities, and PID. Women's role in society has been defined in terms of her reproductive capabilities. A woman's health needs are overridden by liability concerns and fetal protection. Women who have HIV/AIDS are denied clinical trials largely because of these factors.

Public channels of care are often dehumanizing, discontinuous and disease oriented. General communication by staff and attitudes of doctors and nurses are poor. Little attention is spent on prevention. In a study done in East Harlem the use of multiple services by women depended on previous experience, time available, seriousness of the problem, and the lay referral network. At each step of the health care system the women is faced with analysis and barriers.

RECOMMENDATIONS

1. Health care services can not assume that women are a homogeneous group. Appropriate services require data that profile women's diverse needs. Existing and demonstration services must be developed and evaluated to fit particular needs with an emphasis on the impact of social problems.

2. Integrate and link comprehensive services that includes not only the individual woman but the family, community, and social system that impacts her.

3. Improve responsiveness to women's needs by caregivers (health professional, clergy, police, teachers) and human service providers (schools, churches, welfare system, law enforcement, legal services). Include training material that focuses on special problems of women, identification of disease, treatment, and appropriate communication.

4. Include women's services such as rape crisis shelters, battered women services, drug treatment, child care, etc. in national health policy.

5. Educate the public about women's health needs and available services in order to overcome moral judgement and discrimination; outreach and early intervention are necessary to prevent HIV transmission.

6. Increase child care and respite care. Child care plays a crucial role in ensuring that women have access to treatment. For example, in one residential drug treatment program there was a 33% increase in utilization by women clients when residential services for both mothers and children were offered. In another case utilization by women of a clinic increased from 33% to 50% when child care was instituted (Naierman, N. "Sex discrimination in Health and HUman Services. Washington D.C. 1979).

7. Allow community participation in the planning, delivery, and evaluation of services including developing community coalitions, employing indigenous personnel and enabling community control. Develop innovative and demonstration programs utilizing in-home paraprofessional health care workers, train community leaders in health care and social problems, establish local/ community clinics that are accessible and representative of populations to be served.

PREPARED STATEMENT OF NEIL FLYNN, M.D.

I wish to thank Representative Boxer for the opportunity to testify to this committee. I am medical director of two HIV clinics in Sacramento with a combined patient population of nearly 700. One of them is a University Hospital clinic and the other is a private, non-profit clinic devoted to caring for people with HIV (PWHIV). Between them they provide most of the care for Medi-Cal patients and women with HIV (WWHIV) in the Sacramento area, with a population of about one million. Seventeen cases of AIDS have occurred in women in Sacramento County and an additional 30 are being followed for HIV infection. The problems of WWHIV are those of all PWHIV, frequently accentuated by their status as women, as well as problems unique to women or greatly magnified because they are women.

As a medical provider it is my responsibility to see that appropriate medical care is received by each PWHIV. We are also responsible for assisting the patient in gaining access to psychosocial care. We are assisted in this responsibility by other professionals in case management, counseling, drug treatment, social services, etc. I would like to relate to this committee the problems we encounter in assuring medical care and basic social services for PWHIV, particularly WWHIV.

It is difficult for WWHIV to find an AIDS knowledgeable medical provider. Most WWHIV must rely on Medicaid (in California, Medi-Cal) to pay for their care. This is because many of the WWHIV are or have been IV drug users or, when they become ill and lose their jobs, they are young and have no financial security to fall back on. Over 60% of WWHIV must rely on public funding of their medical care. A woman with Medi-Cal has great difficulty finding a medical provider. In Sacramento, virtually the only places she can go are the University AIDS clinic and CARES, the private, non-profit clinic for PWHIV. However, as the number of Medi-Cal PWHIV increases, these two sources of care may be unable to continue to provide care because Medi-Cal reimbursement has fallen so low that it does not even cover overhead expenses of an efficient clinic. For example, for every one dollar that the clinics charge Medi-Cal, the reimbursement is only 42 cents at CARES, and 33 cents at the University Clinic. Overhead at CARES, including the salaries of the medical, psychosocial and education personnel is at least 90 cents. Therefore, we must make up the difference from fundraising, private pay and private insurance billings, etc. With a load of nearly 60% Medi-Cal patients in each clinic, this has proven nearly impossible to do. There is a real and present danger that these two sources of care for WWHIV will have to limit their care of patients with Medi-Cal. These patients will then have no place to go, unless to County clinics which are already overburdened. The prospect is that their care is going to fall below even minimum standards unless Medi-Cal reimbursement is significantly increased. To compound the problem of finding a medical provider for a WWHIV, the care of PWHIV is difficult, time-consuming, and requires specialized knowledge -- all features that will keep community physicians from taking PWHIV, let alone Medi-Cal PWHIV at reimbursement rates that don't even cover the overhead of running an office.

The second problem I see arising is a shift of care from current sources to county-run clinics, which are already overburdened and underfunded and understaffed. The reason for this shift is that we are now capable of preventing serious illness in PWHIV for several years using AZT and medications that prevent opportunistic infections. While this is good news to PWHIV, it may delay them from getting Medi-Cal, which is usually available to them when they become disabled by illness or develop full-blown AIDS. Until then, people who rely on public funding for their medical care will receive it from county clinics. WWHIV are more likely to fall into this category for reasons already presented here today. The county clinics are not prepared for this shift.

My final point this morning is that there is insufficient emphasis on prevention of HIV infection among women. Women who use IV drugs have not been sufficiently educated about HIV avoidance. There are insufficient drug treatment facilities for such women. Multipartnered heterosexual women are 3 to 5 times more likely to acquire HIV than are multipartnered heterosexual men. Sexually active women must receive more education about HIV avoidance.

In summary, as a physician providing care to WWHIV, I see for them an increasing inability to find expert medical care if they must rely on publicly-funded medical care, for two reasons -- inadequate reimbursement by Medicaid to even cover outpatient office overhead, and delay in becoming eligible for Medicaid due to advances in early intervention, which delay the onset of illness that might qualify them for Medicaid. They will have to seek care at county clinics, and the funding of those clinics is already inadequate. And, not enough is being done to protect women from infection with HIV.

Thank you.

PREPARED STATEMENT OF MS. DAVIS, WOMAN WITH AIDS

Approximately 10% of the culmulative cases of full-blown AIDS have been women. In New York City, AIDS is the primary cause of death for women between the ages of 25 and 34. It is now estimated that over 100,000 women in the United States are now infected with HIV. Worldwide, women account for 2 of the 6 million now believed infected with HIV.

Recognition of women with HIV within the health care system remains poor at best. By classifying women into neat, at risk populations such as sexual partners of IVDU's, drug users, and sexual partner's of bisexual men. what happens to the women who are infected but don't generally fit into these criteria? Many women will not fit into these at risk populations and will remain undiagnosed because of this bias. Also, because of sexual bias issues, there is a general denial of the possibility of HIV infection in women.

A physician can not "identify" women at risk solely by these parameters. Also, how can you tell whether a women is at risk for HIV with the 5 minute office visits often given within the health care community. I propose different criteria have to be used in the diagnosis of HIV among women as follows.

Women experience some manifestations of HIV that are gender specific. Moreover, because the criteria for an AIDS diagnosis was based mainly on men as a model, women don't fit into the criteria of an AIDS diagnosis. As a result of this bias, many women die without an AIDS diagnosis, without treatment, and without public assistance. This also includes insurance all people with AIDS should be entitled to. The CDC has to allow for these differences in gender and change it's criteria, in order to escape the charge of sexual bias.

Some of the symptoms often seen in women with HIV are:

Respiratory Infections
Chronic Fatigue
Yeast Infections, Vaginal, and Systemic
Pelvic Inflammatory Disease and Cervical Abnormalities
Diarrhea

For intance, many problems with chronic fatigue stem from HIV decimating the immune system. However, chronic fatigue, can also be caused by systemic candidiasis, chronic vaginal yeast infections, and diarrhea. If a HIV+ women complains of chronic fatigue, don't dismiss it as just HIV infection, but also look for other causes that are gender specific such as problems with candidia.

What makes this infection$ different for women?

Women who are currently being diagnosed, are from minority groups within the U.S., and are often poor, and lack resources with which to fight this disease.

Because women with HIV are still the primary caregivers within the family, many women put their own health care issues on hold, often at their own expense, if someone such as her husband or child is also sick with HIV. Women tend to be more socially isolated and lack positive support systems. Also, many lack basic transportation which puts them more at risk for social isolation within our community. Respite care for them from childcare, is nonexistant in our community at this time.

Also, a common health issue among women is pregnancy. Women have been excluded from clinical trials largely because of their reproductive capabilities. Largely because of the thalidomide problem in the 50's, pharmaceutical companies are reluctant to allow women access to medical treatment. This has to change if women are going to be on an equal basis with men in access to health care.

PREPARED STATEMENT OF LEN McCANDLISS

The Sierra Foundation

- The Sierra Foundation (TSF) is a private, nonprofit, independent foundation which awards grants in support of health and health-related activities in 26 Northern California counties.
- TSF grants approximately $ 4 million per year on health and health-related activities in TSF region.
- Areas of particular need currently focused upon are AIDS and Prenatal Care Access.

Access to Care

- Situation continually getting worse, especially in rural areas of California and the country;
- Over 20% of Californians are uninsured;
- Eligibility process for Medi-Cal is a deterrent to the client;
- Provider perception is that reimbursement under Medi-Cal is marginally worth the administrative effort;
- Contributors to the problem:
  - Elimination of the National Health Service Corps;
  - Drain of private health providers into "closed" health maintenance organizations;
  - Cost of insuring employees increasing, resulting in reduced coverage and more out-of-pocket costs to the insured;

Cost of Health Care

- Contributors to the rising costs:
  - An aging population with longer expected life spans;
  - Inability of decision-makers to analyze the cost/benefits of care, and to make the hard decisions related to priority of health care services;
  - Policy-makers taking the short-term view: not adequately funding prevention (e.g., prenatal care);
  - Providers' fear of malpractice resulting in the practice of "defensive medicine";
  - Competitors feeling the need to provide a full menu of services and no one controlling investments (e.g., MRI);

Recommendations

- Promote regional health planning and delivery of health services;
- Develop incentives to serve those with limited access, such as the welfare client, the uninsured and those residing in rural communities (e.g., reinstate the National Health Services Corps);
- Recognize that health care dollars are finite, and that hard decisions need to be made regarding what care will be provided and to whom;
- Develop and support training programs to upgrade the service capacities of physician-extenders such as nurse practitioners and physician assistants;
- Accept that health care cannot be evaluated without looking at the broader societal issues such as economics, employment and education.

PREPARED STATEMENT OF RANDI L. HARRY

Chairman Boxer, distinguished members of the House Budget Committee Task Force on Human Resources, thank you for this opportunity to share my views on the problems of cost and access in health care today.

The biggest problem is that hospitals are being held financially accountable for circumstances beyond their control. I'd like to address overall healthcare resources, the distribution of dollars between government and private insurers, and the problems of access to healthcare services.

Victor R. Fuchs, a Stanford health economist, observes that in the period 1947-1987 health care spending grew 2.5% faster per year than other spending, and that it now consumes more than 11 percent of the gross national product.

Consider the Reasons for Increased Costs...

Aging population--The older we get, the more medical care we need. And it's no secret, our population is aging. People between the ages of 65 and 69 use twice the healthcare resources of those under 65. And those over 85 use two-and-a-half times the healthcare resources of the 65-to-69 group.

Technology--It's wonderful...but it's expensive. For instance, the new drug, TPA, greatly increases the chances of surviving a heart attack, but a single dose can cost as much as $2,200. Yet, in order to remain competitive, hospitals and physicians must offer such new technology, or risk losing patients to other hospitals who do.

New Diseases--The AIDS epidemic has added enormously to healthcare spending, with long, costly treatment for terminally ill patients. AIDS is only the most recent example. Tomorrow, it may be something else.

Social Diseases--We are a nation of addictions, and that exacts a toll on the healthcare system. Drug and Alcohol abuse are not only physically damaging to the user, but bring along with them all sorts of related health care burdens for society: auto accidents, drive-by shootings, domestic beatings, birth defects...all related to substance abuse, and all left on the doorstep of the healthcare system. The breakdown of the family is another social problem that leaves millions of elderly without long-term care options.

Personnel Shortages--In a supply and demand economy, the supply of healthcare workers, particularly nurses, is not keeping up with the demand for healthcare services. This drives up wages, and forces hospitals to either charge more or staff less.

Physician Incentives--Hospitals don't admit patients or discharge them, nor do they order tests such as X-Rays and Lab work. Physicians do all these things. Under the current system, the more Physicians do, the more they get paid. And the less they do, the more vulnerable they are to malpractice litigation. So the current system actually encourages over-testing and over-treatment, and that means unnecessary spending. Hospitals have some control over unit costs, but they have no control over the number of units. That's controlled by physicians.

Now Consider Government's Response So Far...

In the last decade, state and federal governments have consistently shifted costs back to hospitals. If hospitals are unable to make up the difference elsewhere, costs go up for privately insured patients.

Medi-Cal--There is no real negotiation on selective contracts with Medi-Cal...it's more of a take-it-or-leave-it situation. What hospitals are being asked to take, is less than 61% of the cost of treating Medi-Cal patients. At UC Davis Medical Center, for instance, we lost $47.4 million on Medi-Cal patients in fiscal 1990 alone.

Medicare--When the present system was introduced, it was intended that Medicare rates would increase with "market basket" rates. Since that time, however, Medicare rates have increased at 1-2% less than "market basket." This is an effort to force hospitals to make up the difference by operating more efficiently. After several years of this, hospitals are now reimbursed for about 92% of their actual cost of treating patients. To take UC Davis Medical Center as an example again, we lost $1.6 million on Medicare patients in fiscal 1990, and that would have been even greater if we were not a teaching hospital, subject to certain exemptions.

The Medically Indigent Services Program--In 1983, the State of California transferred responsibility for medically indigent patients to the counties. But they transferred only 70% of the funds, and the shortfall was never made up. Again, that translates into money lost by healthcare providers.

Uninsured and Charity Cases--Five million Californians have no private health insurance and are ineligible for public healthcare programs...that's 21% of the population. More money lost by healthcare providers.

The Result: Access to Healthcare Services is Increasingly Limited

Physicians in Private Practice find the billing requirements associated with Medicare and Medi-Cal patients discouraging. Often, it's not worth their while to see these patients. The perception among physicians is that these patients are more litigious. And while this is not necessarily true, these patients

do tend to be high risk. They tend to be poorly nourished, more seriously ill, less compliant with treatment, and more likely to have substance abuse problems than privately insured patients.

Patients increasingly fail to accept responsibility for their own health. Obstetrics is the most graphic example. The consumer perception is that someone is to blame when a child is born with a problem. And the easiest target is the obstetrician. As a result, obstetric malpractice insurance has risen to the point where more and more of these specialists are confining their practice to gynecology, making it very difficult to find an obstetrician when you need one. Now imagine someone on Medi-Cal trying to find an obstetrician. That helps explain why last year, 23% of the mothers who delivered at UC Davis Medical Center had received no prenatal care.

What happens when Hospitals are full? Under the current system, if a hospital wants to stay profitable, there is little room for surplus beds and even less money for expansion. Yet, it is unrealistic to expect a hospital to operate at capacity all the time. What's more, it's dangerous. It's not as simple as filling every bed: men must be separated from women, children must be separated from obstetrics, and so on. When a hospital is at 85% capacity, patients are in the halls.

California hospitals, on average, operate at 64.2% capacity. But Sacramento is different: only one hospital averages 65%, and the others range from 74-85%.

The capacity problem is particularly acute for hospitals providing regional trauma care, such as ours. For a full week last month, we were forced to declare an internal disaster, canceling all elective procedures, and turning away all but the most serious trauma cases to other hospitals. We have 471 beds, and we were at capacity. One plane crash or one school bus accident would have put us over the edge.

Summary

If a hospital has done all it can to increase the efficiency of the operation, if it has raised charges to private-paying patients as high as it dares, if it has slashed staffing to the point of pain...and it still can't recover its costs, what's next? I don't think our society is ready for rationing of medical services, and I refuse to believe that's the only alternative.

Thank you.

PREPARED STATEMENT OF RONALD L. USHER

Thank you for the opportunity to present my views on health care cost and access issues. I offer a county government perspective. Since 1978, I have served as director of the Sacramento County Health Department. We are responsible for public health, medical, mental health, and substance abuse services in a growing urban county of over one million people. Sacramento is the hub of a much larger region. Various of the medical services located here draw patients from adjacent and distant areas populated by another 500,000 to a million people. What happens in Sacramento is vitally important to people who reside in or travel through Northern California.

Although there are many issues which deserve the attention of your task force, I'd like to focus on two which are particularly compelling. First, I'll offer comments on the worsening crisis in emergency medical services. Then, I'll discuss the plight of medically indigent persons, including those who must rely on California's failing Medi-Cal program.

Emergency medical services in Sacramento County are now receiving a lot of attention. Identified problems include a disorganized system of ambulance response involving seven separate private companies and some local fire agencies. It is an arrangement which was established when Sacramento was less populous and current complexities of congestion were not in evidence. Ambulance response times now frequently fall below acceptable standards. The system relies on an archaic communications system which needs major overhaul. These are problems which can be addressed, but only with resources which we have yet to identify. Furthermore, our problems are not limited to pre-hospital care. We face serious issues of accessibility at the eleven hospitals in the Sacramento area.

There is no county hospital in Sacramento County. The University of California Davis Medical Center provides significant emergency and indigent care services. It is our only trauma center, drawing patients from a vast geographical region. As such, UCDMC experiences recurring overload. Recently, an internal disaster was declared to facilitate the moving of patients so that the door for new trauma patients would remain open. The other local hospitals provide basic emergency services, and all of those within the county boundaries except for the two Kaiser facilities have contracted with Sacramento County to provide indigent care.

In recent years, it has become clear that hospital based emergency care is not adequate to meet the demands of our growing population. Diversion of ambulances did not happen a few years ago. Now, it is a daily occurrence for other than immediate life-threatening cases. The hours of diversion are increasing each year. It is not unusual for several hospitals to be on diversion status at the same time. If this trend continues, there is no doubt that death and serious disability will result when people in ambulances cannot access essential hospital based care promptly.

Reasons for ambulance diversions vary. Some hospital emergency rooms are too small; other facilities lack capacity elsewhere on the premises so patients on gurneys fill up the emergency rooms. There are medical specialist shortages in some fields and geographical areas.

While these explanations differ, one overriding conclusion is inescapable: Present incentives in the health care system do not encourage those who make private sector decisions to address the problem of public access to necessary health care. Although economics are certainly involved here, we are not talking only about serving indigents. Emergency medical care access is an issue for everyone. If the facilities and resources are not there when they are needed, it doesn't matter how much ability a given patient has to arrange for payment. This is a major community problem which Sacramento County is trying to address, but our efforts to find solutions are constrained by the fragmentation, lack of resources, and perverse incentives in the total health care system.

Shifting focus to indigent care, let me offer a brief review of another worsening situation. The plight of the uninsured is now well known, here in California as it is elsewhere. Various reforms have been proposed, but nothing meaningful has been enacted to relieve the increasing burden on the people who need to be served and on the counties as providers of last resort.

Here in Sacramento County, we opposed the shift of the non-federally funded medically indigent adults from state to county responsibility in 1982. We found no plausible justification for a public policy which guaranteed that indigent people would be treated differently depending on where they lived. Losing that battle, we then set about to create a managed care system which has received national recognition. It provides necessary care to those who need it through a combination of county and private provider services. It continues to assure access, despite depletion of state funding. That has been possible because the

Sacramento County Board of Supervisors has used local tax money to backfill horrendous state budget cuts which could have decimated the program. Only a few weeks ago, our Board chose to cover the latest $6.5 million cut with virtually all of the local revenue which otherwise would have been available to expand other public services in a rapidly growing county. This happened because the threatened medical service reductions would have reduced available indigent care services to only the direst emergencies. Our Board would not accept that alternative as befitting a civilized society.

Although our indigent care program has survived for now, we are worried about the future. Indications from state government are that next year will be much worse.

Beyond the county program, there is another level of increasing concern. California's Medi-Cal program is rapidly deteriorating. Here in Sacramento, county responsibility medically indigent persons now have better access to care than do many state responsibility Medi-Cal patients. We know that because we see increasing numbers of Medi-Cal patients at our primary care clinics -- patients who require specialty services which our clinics do not provide. These patients come to us because they cannot find private sector specialists who will treat them at Medi-Cal rates and under the bureaucratic processes of the state program.

I am referring here to pregnant women who cannot obtain prenatal care, who will show up at hospital emergency rooms when they are ready to deliver. I am talking about Medi-Cal eligible persons who go to emergency rooms for stabilization of broken bones, but who then cannot find orthopedists for follow-up care. Dentists in this community will not accept new Medi-Cal patients because the reimbursement level is so low that they cannot even cover the laboratory costs of a typical patient visit. One-third of the admissions to our psychiatric health facility are Medi-Cal eligible persons who we serve without reimbursement because they cannot access services elsewhere.

What might the U.S. House of Representatives do about these problems? The federal government is a partner in the Medi-Cal program. Access to health care is a matter of national concern. The problems are worsening. All variety of solutions have been suggested. It is time for dialogue to be concluded and for Congress to enact a comprehensive approach which promises to address the issues rather than to continue to avoid them. Without such action, the crisis will surely get worse.

Thank you for inviting my participation in your consideration of this important matter.

PREPARED STATEMENT OF NANCY FINDEISEN

Presentation prepared by Nancy Findeisen, Executive Director and presented by Mary Irwin, Planning and Research Director
Community Services Planning Council, Inc.

Thank you, Congresswoman Boxer and Members and Staff of the Committee, for giving our community an opportunity to speak to the critical issue of health care access by holding this hearing in the Sacramento region. I will be speaking to health care access particularly as it relates to children and families.

1. The first access issue relates to cultural diversity.

Sacramento is one of the fastest growing regions in the country. Our population is growing in numbers as well as diversity. Today almost 40% of the students in Sacramento County schools are children of color, an increase from about 28% in 1977. Currently, in area schools, about 15,000 students have limited English proficiency. In fact, over 50 different languages are spoken by Sacramento school children.

Access to health care for these children and their families requires extensive outreach to new immigrant families, translation services and staff sensitive to, and familiar with, cultural differences. Federal support for translation services, culturally sensitive public health outreach services, and programs to train racial and ethnic minorities for professional and paraprofessional positions in the health care field are all key elements in promoting adequate access to health care for the diverse population we have in our region.

2. The second access concern centers on family planning programs.

Sacramento County teenagers give birth at a higher rate than their counterparts statewide. In 1986, 11.7 percent of all births were to teenagers, compared to 10.9 percent statewide. In some communities within the county, more than one out of five births is to a teenage mother. Federal support for family planning services can prevent unwanted adolescent pregnancies, helping young women postpone pregnancies until they are able to support and care for a child. More family planning services provided in clinics located in communities with high teen birth rates are needed. Federal dollars are needed to fund these clinics which provide services to poor and isolated populations.

3. The third access problem has to do with location of services.

Childhood immunizations provide the foundation for community preventive health care. The percentage of children who have not been fully immunized before entering kindergarten has been declining in recent years. For example, in 1987 only seven percent of Sacramento children entering school needed additional shots. In spite of this overall positive trend, in certain areas of our community, many children still enter school with incomplete or no immunization records. In addition many of these children have limited access to health care due to poverty and a paucity of health care providers in their neighborhood.

One promising program that addresses this issue is the co-location of health care and social services on school campuses, particularly elementary school sites. This is especially successful if the

school is centrally located and is viewed somewhat as a community center by the neighborhood. One such clinic exists in Sacramento, supported by Cities in Schools, and private non-profit organizations, Health for All, a non-profit health care provider, and the County Health Department. The clinic is located on the campus of Freeport Elementary School in South Sacramento. The Department of Social Services and the City Parks and Community Services Department also provide services on the school site.

On the first day of school this year, 20 students were referred to the Freeport Clinic for immunizations. Had the clinic not been there, the students would have been denied entry into school until they could show proof of immunizations, thereby forcing their absenteeism for one or several days. Health care professionals and school nurses involved in health screening programs, such as are now provided at the Freeport Clinic, report finding serious, untreated health disorders in young children. In such instances, clinic staff help the family obtain appropriate health care. The clinic's goal is to include the entire family in health care prevention and treatment.

Federal support for clinics like the Freeport model would assist communities in developing quality preventive health care programs. The Freeport school model is an excellent example of this.

4. The fourth access issue is health care insurance.

Over 2,000 physicians serve the Sacramento area. However, not all citizens receive adequate care, due chiefly to the significant number of individuals who do not have insurance coverage. A majority of the new jobs being created in the region are in the service and retail category. Some of these jobs are temporary or part-time and many workers in these jobs have no health care benefits. A single mother working in an entry level position or two parent family with both parents working for minimum wages both find themselves with incomes below the federal poverty standard. Twenty-two percent of working people in California do not have health insurance of any kind, and ethnic minorities are more likely to be uninsured. For those whose income is above the eligibility level for Medi-Cal but who cannot afford the typical $150 or more per month for health insurance, routine health needs tend not to be addressed and the risk of serious illness increases. Lack of health care insurance is a critical problem for the working poor, despite their employed status. These people have no recourse but to depend on an underfunded and overextended public health care system.

In summary, the federal government can and should provide both policy and financial support for health care initiatives that improve access to quality health care for all people. There are four areas that warrant particular federal support. These are:

1. translation services, culturally sensitive public health outreach activities, and training to enable more ethnic minorities to enter health care professions;

2. family planning services, particularly in high-risk communities;

3. comprehensive health care services provided on or adjacent to schools, especially elementary schools; and,

4. universal health care coverage, especially aimed at helping the working poor.

[Whereupon, at 12:01 p.m., the hearing was adjourned.]